UNIVERSITY OF ALBERTA

DEVELOPING NATIVE HEALTH SERVICES IN CANADA: BEYOND THE HEALTH TRANSFER POLICY

BY

ELIZABETH MARIE OLSEN ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF ARTS.

DEPARTMENT OF ANTHROPOLOGY

Edmonton, Alberta
FALL 1993

National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file   Votre référence

Our file   Notre référence

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-88373-1

Canada

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: ELIZABETH MARIE OLSEN

TITLE OF THESIS: DEVELOPING NATIVE HEALTH SERVICES IN CANADA: BEYOND THE HEALTH TRANSFER POLICY

DEGREE: MASTER OF ARTS

YEAR THIS DEGREE GRANTED: 1993

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

E. Olsen

August 30, 1993

9652 - 83 Avenue
Edmonton, Alberta
T6C 1C2

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled DEVELOPING NATIVE HEALTH SERVICES IN CANADA: BEYOND THE HEALTH TRANSFER POLICY submitted by ELIZABETH MARIE OLSEN in partial fulfillment of the requirements for the degree of MASTER OF ARTS.

David E. Young
Dr. David E. Young

Dr. Roderick Wilson

Gurston Dacks
Dr. Gurston Dacks

august 27, 1993

ABSTRACT

Government-based, biomedical services have reached their limits in being able to improve the overall health of Native people. Innovative, preventive and broad-based solutions in which Native communities participate fully are needed to address Native health problems and create health care options, or medical pluralism, for Native people.

Most recently, the Canadian government has responded to the call for Native community participation in health service delivery with its Health Program Transfer Initiative. This initiative transfers administrative control over certain health services to Native communities south of the Yukon and Northwest Territories. Health and Welfare Canada claims that its policy will facilitate the design and implementation of health services more suited to the needs of First Nations communities because they will be designed and run by the communities themselves. However, a discussion of the policy highlights its restrictive nature and the need for new approaches to developing innovative Native health care services.

This thesis proposes a mid-range approach to developing Native health services between the extremes of assimilation of Native people into the Canadian health care system and their complete separation from it. Achieving this balance requires that compromises are reached among Native communities, the federal government and health professionals on a number of issues from funding arrangements to the role of Native traditions in health service delivery. Mid-range solutions are supported as those most likely to expand the range of legitimate health care options for Native people and to foster medical pluralism.

Though I believe that Native self-government and constitutional solutions are necessary for Native health development, this thesis does not focus on these issues. Rather, it focuses on practical solutions which can be achieved in the meantime.

ACKNOWLEDGEMENTS

I express my gratitude to Dr. David Young, my supervisor, for his assistance with this project and for encouraging me to become involved in other academic pursuits throughout my graduate program. I also thank my committee members, Dr. Rod Wilson and Dr. Gurston Dacks, for their helpful comments regarding my thesis.

The generosity of several individuals who took the time to speak with me about Native health development, but who chose to remain nameless, also is greatly appreciated. As well, I am grateful for the assistance of the Alberta Indian Health Care Commission and Medical Services Branch in Edmonton who provided me with research material from their respective libraries. Thanks also to scholars Dara Culhane, John O'Neil and Sally Weaver for responding to my inquiries.

I truly am indebted to friends and family members who supported and encouraged me during my graduate program. In particular, I would like to thank my friends, Zuzana Forgac, Sheree Ronaasen, Jean Lindsay and Karen Anielski; my parents, William and Linda Olsen; and, especially, my partner, Chris Helman.

This document represents my own attempts to synthesize information on Native health development in Canada and communicate it within a thesis format. It does not represent the views of any particular organization. I am solely responsible for any errors or omissions herein.

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION

The Problem: Developing Native Health Services......... 1
Federal Government Health Transfer Policy.............. 5
Policy Options for Transfer............................ 7
Overview of Thesis..................................... 9
Methodology.. 11

CHAPTER 2 - A CASE FOR MEDICAL PLURALISM AND COMMUNITY CONTROL

Introduction... 13
Limits of Biomedicine.................................. 13
  Biomedicine's Definition of Health................... 13
  Biomedicine and Native Health........................ 16
Medical Pluralism...................................... 19
  What is Meant by Medical Pluralism?.................. 19
  Relevance of Medical Pluralism to Canada............. 20
  Relevance of Medical Pluralism for Native Canadians.. 22
Community Control...................................... 24
  What is Meant by Community Control?.................. 24
  Canada's Moves Toward Community Control.............. 27
  Community Control for Native Canadians............... 29
The Transfer Process................................... 31
Conclusion... 33

CHAPTER 3 - THE HEALTH PROGRAM TRANSFER INITIATIVE

Introduction... 34
Background to the Policy............................... 34
  Early Phase.. 34
  Contemporary Phase................................... 38
  1979 Indian Health Policy............................ 40
  From 1979 to 1986.................................... 43
Terms and Conditions of Transfer....................... 48
  MSB's Stated Goals................................... 48
  Programs Eligible and Ineligible for Transfer........ 49
  The Transfer Process................................. 51
Analysis of the Policy................................. 52
  Degree of Control Transferred........................ 53
  Does MSB Prepare Communities for Transfer?........... 63
  Degree of Professional Support for Transfer.......... 67
  Prospects for Developing Health Care Options......... 72
  Prospects for Improving Native Health Status......... 75
Conclusion... 76

CHAPTER 4 - THE RANGE OF OPTIONS

Introduction.. 80
Assimilation.. 82
Separation.. 83
The Middle Ground................................... 83
  Community Control................................. 85
  Funding... 89
  Health Care Orientation........................... 91
  Community Involvement............................. 98
  Native Traditions................................. 102
  Professional and Outside Support.................. 105
Conclusion.. 107

CHAPTER 5 - CONCLUSION.............................. 109

BIBLIOGRAPHY.. 112

CHAPTER 1

INTRODUCTION

The Problem: Developing Native Health Services

The poor health status of Native Canadians is a topic around which there has been a great deal of discussion and concern. It is widely accepted that Native health in Canada is much worse than the health of the Canadian population at large. There is also a growing acceptance of the idea that solutions to Native health problems require broad-based community development and not more and better medical intervention. The most disruptive health problems in Native communities are outside the reach of medical professionals to solve, as they are generated by social disorganization and economic disparity.

Since the time of European contact with indigenous peoples in North America, Native societies have undergone dramatic changes, many of which have severely compromised their health and well-being. For instance, epidemics, the depletion of wild food sources, missionization, re-settlement onto reserves, attempted assimilation through boarding schools and racism have led to social, physical and psychological breakdown in Native communities. Furthermore, the colonial-style relationship between Native people and the federal government, in which Native control over their own affairs is minimal, and in which Native people rely heavily on welfare payments, has compromised Native health by stripping Native people of their independence and meaningful participation in society.

Today, Native people are assessed as being the most disadvantaged segment of the Canadian population: "By virtually every available measure of economic and social well-being used in North American society, Native Indians remain the most destitute of all groups in Canada" (Jarvis and Boldt 1982:1346). And, though the disease profile of Native Canadians is different from that of the Third World (Young 1983), the living conditions of Native and Third World communities often are compared because many Native communities lack basic amenities such as running water, proper sanitation systems and adequate housing.

Research from several areas points to the importance of letting Native communities determine their own needs and develop and run their own services to meet these needs (Health and Welfare Canada 1986a; Madan 1987; Neufeldt 1989; Oakley 1989; Randle 1986; World Health Organization 1978, 1988; Young and Smith 1992; Zakus and Hastings 1989). The international health community, academics and Native people alike agree that self-determination and empowerment for indigenous peoples is necessary for their overall health and well-being. Governments finally have begun to acknowlege the need for Native control and to admit what Native people have known all along - that health problems are linked to Native people's marginal status in our society and to their lack of control over their own affairs, including over their health care services.

In an effort to alleviate these problems, community-level involvement and local control over basic services is being encouraged; and, services which are more accessible to community members gradually are being developed. As Native people have begun to take control over their health services, they have begun to adapt and change them to reflect their own health needs and views. Health services which are distinct from standard biomedical services are being developed in some communities. For instance, we are seeing an increase in preventive, community-based solutions to health problems, which are more suitable for treating psychosocial ills and which are more in line with traditional Native values. In fact, a recent resurgence of interest in traditional Native culture has led to a greater emphasis on traditional Native healing practices and philosophies in community health care plans.

This traditional approach to health and healing reflects a holistic perspective which is prominant in Native cultures.

Health and well-being, from a holistic perspective, consist of a state of balance and harmony within an individual and between that individual and his or her social and physical environment. In contrast to this view of health is the biomedical perspective, which defines health as the absence of disease pathogens in the body. Though effective in treating acute illnesses with drugs or surgery, biomedicine is not well-equipped to deal with chronic illnesses or psychosocial and environmental causes of poor health. These problems require a more preventive and holistic approach. Biomedicine, however, has assumed a monopolistic position in the world and has narrowed the range of health care options; biomedical personnel often even overlook or disparage methods outside of the biomedical model.

It is vital that we broaden our definition of health in this society to allow for the development of alternative approaches to 'health care' which can operate legitimately outside of, or in concert with, the biomedical system. By doing so, we are acknowledging the many factors which impinge upon health and well-being; and, we are acknowledging the pluralistic or multicultural nature of our society which contains an array of valid health beliefs and practices. Allowing alternative health care systems to develop will expand our range of health care options and better meet the health needs of all members of our society

- Native peoples, members of minority ethnic groups and the population at large.

Federal Government Health Transfer Policy

How may health care alternatives be fostered, however? One step in this direction among Native communities is being taken through a recent federal government policy known as the Health Program Transfer Initiative (Health and Welfare Canada 1986b). The transfer policy has made certain aspects of Health and Welfare Canada's Indian health programs and services available for transfer from the federal level to Native communities. Presently, the federal government is transferring administrative control over these programs and services. This administrative transfer has been accomplished to varying degrees across the country.

It is necessary, here, to distinguish between two government health transfer initiatives, the Health Program Transfer Initiative to First Nations communities in southern Canada and the transfer process in the Northwest Territories. They differ in that the southern process transfers control over health care services from Health and Welfare Canada to individual Bands and communities, while the northern version, which was begun in 1982 and completed in 1988, transferred control over health services from Health and Welfare Canada to another branch of government, the Government of the Northwest Territories in Yellowknife. Weller (1990) and O'Neil (1990) both provide comprehensive case studies of the Northwest Territories devolution process, some features of which will be mentioned later in this thesis. Health care devolution has been slow to take place in the Yukon because the Yukon Territorial Government has made land claims and economic development issues take precedence over health care issues (Weller 1990). The main focus of this thesis, however, is on the southern policy, the Health Program Transfer Initiative.

Introduction of the Health Program Transfer Initiative was greeted with both optimism and cynicism by Native communities. While it offers them an opportunity to take charge of their health care, it does so on very specific, government-defined terms. Some groups have been willing to work within the confines of these terms, while others have rejected them outright. Undoubtedly, there are problems with the policy which raise serious doubts about its utility; so far, the implementation process for local control proposed by the transfer policy has not greatly enhanced Native community involvement, local control or the development of health care alternatives for Native people.

Policy Options for Transfer

Transferring control from one level of government to another is not easily accomplished. It involves substantial changes for all of the parties involved. For instance, in transferring rights, powers and responsibilities from one order of government to another, new institutions must be established, new lines of communication and authority must be developed, health personnel must be reoriented and trained (Abele 1990) and community members must become aware and supportive of the health development process. Furthermore, higher levels of government must be willing to support lower levels of government throughout the process.

Current federal policy guiding the transfer of control of Native health services is somewhat limited, as we shall see. Therefore, alternative solutions for developing Native health services need to be proposed in order to move from a federally and professionally-dictated approach to a community-based approach to health care. There is a range of views, even a polarization of opinion, regarding the direction that Native health development should take. Much of the debate surrounds the question of how distinct Native health services should be from the Canadian health care system as a whole. Clearly, the most viable solutions lie somewhere in the middle of this range or continuum, between the extremes of assimilation for Native people into the Canadian health care system and their complete separation from it. Current policy, the Health Program Transfer Initiative, represents one position on this continuum, in which Native people are adopting a system very similar to the one they already have and in which alternative health care solutions are not easily achieved.

Achieving middle-range solutions requires that compromises are reached in a number of different areas by Native people, the federal government and health professionals alike. Compromises most likely will be reached on a community-by-community basis since communities have different needs and desires, and since Native people would most certainly reject a single 'blueprint' approach to the development of their health services. Therefore, the federal government must be willing to negotiate on a community-by-community basis and be open to solutions proposed by Native communities. At the same time, Native people should expect to work within certain limitations since federal resources do have limits.

I foresee that the most difficult aspect of reaching compromises or mid-range solutions will be in terms of conflicts arising from cultural and ideological differences among Native people, the federal government and health professionals. These differences create different sets of expectations in terms of, for instance, how far treaty rights to health care should extend or how far away from a biomedical approach to health care society should go. Mid-range solutions or compromises, then, will not be easy to achieve.

Overview of Thesis

Chapter 2 presents theoretical support in favour of the notion that alternatives to biomedicine should be pursued and that locally designed and controlled Native health services should be supported. This presentation discusses the limits of biomedicine and the benefits of medical pluralism and community involvement in health.

Chapter 3 consists of a discussion of the Health Program Transfer Initiative, the federal government's attempt to foster local control and community involvement in health. The chapter begins with a brief history of the major policy initiatives which led to the inception of the health transfer policy and is followed by a description of the terms and conditions of the policy. Then, the policy is critiqued in terms of its ability to foster the development of successful, locally-controlled Native health services. The following criteria are used: 1) what degree of control is conferred to Native communities through transfer; 2) to what extent is community involvement encouraged; 3) what is the quality of the relationship between the communities and Health and Welfare Canada under this system; and, 4) to what extent is medical pluralism fostered by this arrangement? Evidence points to the conclusion that the health transfer policy is, in its present form, an unsatisfactory process for facilitating local control and the development of health care alternatives. The process has not allowed Native people the freedom to develop health services that are much different from the ones they already have.

Chapter 4 identifies several problem areas which need to be addressed for Native health development to succeed. It identifies, as well, the ranges of opinion within these problem areas and compromise solutions which most likely would lead to the development of health care options in Native communities. This chapter does not posit a single blueprint for Native health development. Rather, it explores mid-range solutions and attempts to map the 'middle ground,' which strikes a balance between the extremes of integrating Native people into the Canadian health care system and of developing completely distinct Native health services. This balance is characterized by medical pluralism, or a range of health care options. The final chapter, Chapter 5, briefly summarizes the preceding chapters.

Methodology

The information used to prepare this thesis was derived from a number of sources including books, scholarly articles, conference proceedings, federal government documents, position papers, taped and transcribed personal interviews, telephone conversations, and casual conversations. The sources which provided the most comprehensive analysis of the Health Program Transfer Initiative were a critical analysis of health transfer by Culhane Speck (1989), a report documenting the proceedings of a 1989 First Nations Health Transfer Forum (Union of Ontario Indians and the Assembly of First Nations 1991), and a short-term evaluation of health transfer prepared by Adrian Gibbons and Associates and published by the Medical Services Branch of National Health and Welfare Canada (1992).

In-depth case studies on the experiences of individual Native communities with transfer are limited. My information, therefore, is drawn from a variety of sources including both written and verbal accounts by community members, administrators, consultants, researchers and Medical Services Branch staff. Written accounts consist of Health and Welfare's health transfer materials (1989a-d, 1990a-d)) for the federal government's description of the policy and process and for statements of its intent. I also have reviewed previous federal Indian policies, including health policies, and secondary sources discussing these policies, in order to place the transfer policy in political and historical perspective. My critique of the transfer process is based on a synthesis of these sources as well as supporting literature on such topics as Native self-government, medical pluralism, cultural pluralism, multicultural health, community development and primary health care. Verbal accounts consist of material from sixteen separate interviews held either in person or over the telephone with individuals directly involved in Native health care. Interview material was used to supplement written accounts and to clarify issues identified in the literature.

CHAPTER 2

A CASE FOR MEDICAL PLURALISM AND COMMUNITY CONTROL

Introduction

What is the evidence in favor of changing the organization of health care systems from government and professional control to local and community control to the extent that alternative approaches may be developed? This chapter provides some of the rationale or theoretical support for such a change, particularly for the development of community-controlled Native health services.

Broadly speaking, this rationale is provided through a discussion of the limits of biomedicine in contrast to the benefits of medical pluralism and community-controlled health services. A case for the development of alternatives and choices for consumers of health care, particularly Native people, should arise out of this discussion.

Limits of Biomedicine

Biomedicine's Definition of Health

It is becoming accepted that there are limits to biomedical services in terms of their ability to meet the health needs of an entire population (Health and Welfare Canada 1986a, 1989e; Lalonde 1974; Leslie 1980; Mahler 1981; Masi 1989) These limits exist despite government and professional efforts to provide universal access to high quality medical care across the nation. Part of the problem lies in biomedicine's limited definition of health. Medical training leads the practitioner to treat and cure diseases. A healthy individual is one who is free from disease. In such a disease-centered model, many factors influencing health and well-being often are overlooked. For instance, rarely is the patient's complaint examined in the context of his or her social, physical or psychological environment; rather, cures and treatments revolve around the diagnosis of particular physical ailments and the treatment or suppression of symptoms. Emotional or psychological problems which can translate into physical complaints often elude biomedical doctors, as they are trained to look for physical pathology and not emotional distress. Underlying environmental causes of the problem also may go unnoticed or remain outside the realm of the doctor's investigation.

In contrast, a holistic approach to health care, typical of non-Western, including Native, societies, considers the whole individual in the context of his or her culture and environment. Fortunately, a holistic perspective is gradually becoming part of the consciousness of health professionals (Masi 1988, 1989), who are beginning to abandon the view that health care lies exclusively within the domain of the medical profession. The World Health Organization (WHO) espouses a view in keeping with this holistic perspective. It considers an individual's physical, mental and social well-being to be a "fundamental human right" and "a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO 1978:2). Nursing practice also includes a holistic view of the patient, as an individual with physical, emotional and spiritual needs. A new branch of nursing called transcultural nursing trains nurses to consider the patient's cultural context and the effect this will have on the patient's care. Generally, however, the biomedical health care system adopts a disease-centered model of health and treats individuals according to very specific physical complaints which require professional, hospital-based care.

This overemphasis on a biomedical model of health care has been costly and ineffective in many cases and has served to alienate average citizens from their own health care. The sophisticated medical knowledge that doctors possess, and the impressive demonstration effects modern medicine can display, lead people to believe that health lies exclusively within the domain of medical care and is not something that they, as individuals, have much control over. The fact that medical practitioners are part of a strictly regulated and bureaucratic system also alienates average citizens from their own health care.

A further cause for alienation from biomedicine is simply its physical inaccessibility to many people. Globally, most people do not have access to biomedical health services on a permanent basis (Mahler 1981). The growing awareness of the limits of biomedicine are, however, leading to recommendations for decentralized, holistic and intersectoral solutions from researchers and government.

Biomedicine and Native Health

It is widely known that the health of Canadian indigenous peoples is far below that of the Canadian population at large. Health statistics reveal a wide discrepancy between the health of Native and non-Native populations (Health and Welfare Canada 1987). Furthermore, patterns of morbidity and mortality vary (Jarvis and Boldt 1982; Musto 1990; Postl 1986; Postl and Moffatt 1988), with a high incidence of infectious diseases such as tuberculosis; rising rates of chronic, lifestyle diseases such as diabetes and alcoholism; and rising rates of mental illness in Native populations. Mental health has become a major focus for concern in Native communities (Nishnawbe-Aski Nation 1990) in response to alarmingly high rates of suicide, family violence and substance abuse. These problems stem from social breakdown and the conditions of poverty.

The curative, medical model of health care adopted by Medical Services Branch (MSB) of Health and Welfare Canada has failed to reverse these health trends in Native communities. Though able to curb epidemic infectious and respiratory diseases and treat acute physical injuries, MSB is ill-equipped to prevent them or to deal with chronic, degenerative diseases and problems such as suicide, violence, accidents and substance abuse. And, though to be commended for providing access to medical services for even the most remote Native communities and for curbing the very high rates of infectious disease and infant mortality in Native communities, biomedicine has done little or nothing to involve local people in their health care.

Health care decisions traditionally have been made by health professionals and bureaucrats without the direct input of local people, creating a pattern of paternalism which is hard to break. The traditional 'colonial' relationship between Native people and the federal government, and between Native people and health professionals, whereby Native power and control are tokenized, has led to passivity, dependency and, in many cases, feelings of hopelessness. In the area of health care, this relationship has nearly destroyed Natives' interest in being responsible for their own health needs (Young, T.K. 1984; Weller 1981).

Another limitation of the medical model adopted by MSB is its uniformity. Designed for the sake of administrative convenience, this system pays little attention to political boundaries and ethnic differences (Weller 1990). In fact, Scott and Conn (1987) argue that the medical model ignores economic and political determinants of health in Native communities and actually obstructs constructive change by giving the impression that health needs are being met when they are not. An overall lack of awareness of Native health needs and Native culture on the part of health service providers also has contributed to the development of generic Native health services.

So, because of different health needs, cultural differences, paternalism, the uniformity of the biomedical model and a lack of awareness of Native issues among bureaucrats and health professionals, Native people have experienced problems with our health care system. This conclusion is not to deride completely the value of biomedicine, for it is invaluable for the treatment of certain conditions; but, it is to acknowledge that a biomedical approach is not always appropriate and that there are problems which stem from adopting such a singular approach to health and disease.

Medical Pluralism

What is Meant by Medical Pluralism?

Medical pluralism refers to the coexistence of a variety of health care and treatment options which creates health care choices for people. Pfifferling argues that "a pluralistically oriented world view presupposes many world views, many paths to experience, and many communication models" and that such a view conflicts with the dominant and restrictive biomedical world view (1981:198). Medical pluralism may also refer, however, to the diversity within a medical system such as biomedicine, to the diversity which exists in people's conceptions of health and illness, and to the variety of perspectives held by health practitioners (Minocha 1980). The first definition is the one most relevant to this discussion: the coexistence of a variety of health care and treatment options, one of which is biomedicine.

Medical pluralism exists in our society, whether or not it is officially acknowledged and fostered. Folk medicine and traditional forms of medicine present choices to people, though they function in the shadow of biomedicine and are often viewed as quackery or 'fringe' practices by health authorities and the public at large. Biomedicine, however, is merely one of numerous 'alternative therapies' which compete with and complement one another (Leslie 1980). Recognition of this fact would help to legitimize these options and make them more available to people.

Relevance of Medical Pluralism to Canada

Pluralism is as relevant to Canada as to any other country in the world. Canada's immigrant and indigenous populations are culturally diverse, and so the range of health care beliefs and expectations of health care is equally diverse. Biomedicine, therefore, cannot be expected to meet everyone's health needs at all times. Options are needed.

Another argument in support of medical pluralism is the valuable contribution that ethnomedical traditions, other than biomedicine, may make to health care for anyone interested in exploring these options. Canada is lagging behind the rest of the world in embracing this concept. Healing systems such as homeopathy and naturopathy, which are well established in other countries and supported through health insurance schemes, are fragmented and expensive to access in Canada. In fact, traditional Native medicine has faced systematic discrimination from mainstream health providers in Canada (O'Neil 1993), making it difficult even for Native people to use.

Health professionals and bureaucrats are beginning to recognize the need for pluralistic approaches to health care. The term 'multicultural health,' for instance, is used frequently by members of the medical profession to describe the trend toward creating culturally-relevant health services. However, their use of the term 'multicultural' usually only implies enlarging biomedicine's scope and improving its ability to treat people from other cultures. It generally does not imply support for the development of alternatives outside of the biomedical model.

Ralph Masi, President of the Canadian Council on Multicultural Health and a Canadian family physician, for instance, has acknowledged the relevance of pluralism to Canadian physicians and recognizes that hospitals and the health care system have not truly acknowledged the multicultural nature of this society. He admits that health care providers still need to examine their biases and how these are manifest in their practices and institutions (Masi 1988). This acknowledgement of bias on the part of biomedical practitioners is a positive step toward expanding the range of health care options in Canada.

Biomedical practitioners, however, also need to acknowledge their limitations and accept the existence and validity of separate ethnomedical systems which meet health, social and cultural needs that they cannot.

Relevance of Medical Pluralism for Native Canadians

Anthropologists usually assume the importance of culture, culture meaning the rules and values shared by a group of people which shape their reality and guide their behavior. So, they would agree with Kymlicka, writing on liberalism, community and culture, that the consideration of cultural membership is "an important part of showing equal concern for individuals" (Kymlicka 1991:166). In fact, cultural membership "seems crucial to personal agency and development" (p.176). Certainly, ignoring culture in the delivery of health services to Native people has had negative consequences. Culture is often overlooked in the provision of medical care because of a focus on biology and disease pathogens. Such a fundamental oversight on the part of service providers creates endless misunderstandings and often leads to an avoidance of the health care system altogether by Native people.

It is important to clarify that the term 'Native' glosses over the cultural diversity, or pluralism, which exists within the Native populatio[illegible] Even though Native peoples share a basic philosophy which includes a respect for life and nature, and a holistic approach to health, they differ in the ways that they express these values. Native people belong to a variety of tribal groups, speak a number of different languages and possess a wide range of customs and traditions. Concepts of health, well-being, illness and disease, and the perceived causes of illness and disease vary from one group to another (Medicine 1988:46). Such cultural diversity precludes a single approach to developing Native health services. Medical pluralism, then, will be an inevitable result of developing health services which are relevant to Native people.

Generally speaking, there are two logical options for creating more relevant health services for Native people: 1) incorporating Native people and their values and beliefs into the present health care system to a greater degree; and 2) allowing Native people to design and run separate services, which most likely will include traditional Native medicine. Both routes are viable, and both are being pursued. Native demands for self-government and self-determination suggest that the choice should be up to Native communities. The literature, and my interviews with Native people, indicate that community health services will include a combination of curative and preventive strategies from the biomedical and Native healing traditions.

The hope for Native communities is that, in combining the two systems, biomedical practitioners do not continue to dominate the health care arena and that they, in fact, take direction from Native health care staff. It is also hoped that Native healers do not become subsumed within the biomedical system but retain their uniqueness. Margaret Wheatley, from the Council for Yukon Indians, envisions "two parallel systems with mutual respect and referrals from one to the other" (Wheatley 1990:219). In order to maintain a system in which professional biomedicine does not dominate over community-generated solutions, however, communities need to be granted a greater deal of control over decision-making pertaining to their health care. The mechanism, then, for fostering the development of real health care options, or medical pluralism, in Native communities would seem to be community control.

Community Control

What is Meant by Community Control?

What does community control or involvement in health mean and entail? Zakus and Hastings (1989) provide a definition which suggests that community involvement in health is a vehicle for achieving medical pluralism as well as Native self-determination in health:

> Public or community involvement in health may be defined as the process by which members of the community, either individually or collectively, develop the capability to assume greater responsibility for assessing their own health needs and problems, for planning and deciding on solutions (including the actual provision of resources), for creating and maintaining organizations in support of these goals, and for evaluating and bringing about necessary adjustments in goals, targets, and programs on an ongoing basis (Zakus and Hastings 1989:180).

Community involvement in health, by this definition, implies community-based and designed services. Community-based services are founded on very different principles from biomedical services. Where biomedical services are characterized by centralization, professionalization, specialization and a curative approach, community-based services are predicated on decentralization, public participation, team approaches, and a preventive, self-help approach to health (Randle 1986).

Though many people undoubtedly have come to equate quality health care with modern medical services provided by health professionals, the experience of community health development experts and of local groups who have taken a greater degree of control over their own affairs has shown that the advantages of a community-based health care system outweigh those of a professionally-controlled system. This experience is reflected in a worldwide movement toward community participation and community-controlled health services. Over the last several years, at least since the World Health Organization's Alma-Ata Declaration of 1978, which called for "Health For All By the Year 2000" (WHO 1978), the themes of community participation and grassroots planning have become popular in health circles worldwide (Haro 1987; Health and Welfare Canada 1986a; Hodes and Musto 1990; Johnston 1990; Madan 1987; Nichter 1984; Oakley 1989; Rifkin 1985; Robinson 1990; Welsch 1986; World Health Organization 1988; Zakus and Hastings 1989).

In order to reduce discrepancies in health throughout the world, the World Health Organization promotes its Primary Health Care (PHC) strategy, the key component of which is Community Involvement in Health (CIH). PHC and CIH both encourage local participation in, and increased local control over, health care. A Primary Health Care approach involves the following features:

> practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO 1978:3).

Health Ministries, in developing countries especially, have been designing Primary Health Care (PHC) programs to meet the health needs of people for whom biomedical, hospital-based health care is economically, culturally or geographically inaccessible. Community involvement in these PHC programs is considered by the World Health Organization to be essential for community health (Oakley 1989).

In 1988, the World Health Organization, reflecting on the Alma Ata Declaration midway between its inception and the year 2000, called on its member states to "accelerate decentralization and socioeconomic and structural reforms which favor active involvement of people" and "to make renewed and innovative efforts to involve people and communities creatively so as to empower them" (WHO 1988:156). In Canada, Health and Welfare's health transfer policy is partly a reflection of this international health philosophy; however, Native communities and the federal government also have been moving in this direction for two decades in response to Native self-government demands.

Canada's Moves Toward Community Control

At least since the 1970s, Health and Welfare Canada and Canadian Native communities have been moving toward the idea and the implementation of community involvement in health care, a broad-based approach to health, and a move away from a hospital-based, bureaucratic and curative approach. This trend is reflected in the health care literature from the 1970s to the present (Young and Smith 1992).

Canada's first major statement on community involvement in health appeared in *A New Perspective on the Health of Canadians: A Working Document,* by former Health and Welfare Minister, Marc Lalonde (Lalonde 1974). Lalonde argued that individual Canadians must assume the responsibility to alter their habits and lifestyles, instead of relying on doctors and high-tech medicine, to prevent the kinds of health problems which are rapidly on the rise, namely chronic diseases and accidents. Healthy lifestyles and healthy environments, he concluded, are the keys to improved health. Though criticized for its overemphasis on individual responsibility, which can lead to 'blaming-the-victim' approaches (Crawford 1977), the Lalonde report nevertheless proposed alternatives to the biomedical model of health.

Since the Lalonde report and Alma Ata, a number of Canadian government documents have assumed a preventive, public participation stance. One major document, *Achieving Health For All: A Framework for Health Promotion,* by former Minister of Health and Welfare, Jake Epp (Health and Welfare Canada 1986a), introduced three strategies for improving the health of Canadians: fostering public participation; strengthening community health services; and coordinating healthy public policy. (The term 'healthy public policy' is used by the World Health Organization to refer to policy developed by any level of government which reflects a concern over the effect of that policy on people's health (O'Neill 1990)).

Jake Epp's health promotion framework has guided much of the research on health funded by Health and Welfare Canada (Health and Welfare Canada 1989e). For instance, it generated a literature review, commissioned by Health and Welfare Canada, on strengthening community health which concluded that community-based services clearly are effective in improving health and well-being (Neufeldt 1989). Zakus and Hastings (1989) reached a similar conclusion in their literature review on health promotion and disease prevention. They discovered a near consensus on the following view:

> public involvement in health, and in health system services decision-making, is a fundamental right and good for society as well as a fundamental means for the optimal achievement of human and societal health and well-being (Zakus and Hastings 1989:183).

Moving from policy to practice is another matter, and it is yet to be seen how Canada will accomplish these aims.

Community Control for Native Canadians

Canadian Native people have been engaged in the gradual process of assuming a greater degree of control over their health services, and of regaining the autonomy and self-respect they once had but which "has been eroded by a century of neo-colonial administration" (Castellano 1988:41). Community control makes sense for Native people because this is how Native societies have governed and organized themselves for thousands of years. Small, extended family groups characterize some tribal societies, even those surviving in the modern world. Organizational features of these societies, such as a minimal degree of social stratification and a consensus approach to decision-making, are still relevant today. As well, traditional tribal identity, language, religion, philosophy and customs are considered to be desirable features of contemporary social institutions for many Native people (Boldt and Long 1985).

For example, the group philosophy which underlies aboriginal societies, whereby "the individual is seen as attaining his place and meaning within the traditions of the community and through performance of communal obligations" (Tennant 1985:324), has survived in the modern world. Cooperation and sharing are ancient features of small-scale societies which ensured their survival for thousands of years and will continue to be advantageous for reversing current negative health trends.

Archbishop Scott, of the Scott-McKay-Bain Health Panel commissioned in 1988 to conduct hearings on health in 28

Native communities, concluded that lifestyle changes, cultural regeneration and autonomy are necessary to improve Native health and that communities must participate fully in their health care (*Canadian Family Physician* 1989). The communities that have been successful in the struggle to regain control over their own affairs, in general, have witnessed improved community morale and decreased violence and illness. Noel Starblanket, former Chief of the National Indian Brotherhood, at the opening ceremonies of the Battleford Indian Health Centre in 1979, linked Native self-government with Native health care status and stated that "structures must be set up so that band representation can participate in the decision making, priority setting, and planning exercises of the health care delivery system..." (Starblanket 1980:Appendix 4). Developing these structures and mechanisms for facilitating the shift to local control is the challenge that is now faced.

The Transfer Process

Clearly, there is ample support for the idea that community-based Native health services and local control should be pursued; but there is still much debate as to how the transfer of health services should occur and how community health services should be developed. Although community participation is being promoted, it often fails to take hold.

The extent of change required to make the transition from an institution-centered to a community-centered health care system is enormous; and it will take time, patience and a sense of purpose on the part of local people, health care professionals and the governments. Transferring control over health care from federal and professional control to Native communities could improve Native health and the quality of services, and could contribute to the self-government process, if certain criteria were met. For instance, Native people need to be interested in assuming, and prepared to assume, control; the federal government has to relinquish enough control to foster and sustain Native involvement; and, the federal government needs to provide support for the process of community development. Furthermore, responsibility needs to extend beyond health matters to include other basic services (Haro 1987).

This observation that responsibility needs to be broad-based coincides with the Native perspective of health transfer as being just one aspect of the overall self-government and community development process (Alberta Indian Health Care Commission 1989b; Postl and Moffat 1988; Quinney 1989). Health and Welfare Canada also has acknowledged the importance of broad-based community development in its 1979 Indian Health Policy (Government of Canada 1979). However, it has been accused of not having lived up to this commitment in the implementation of its health transfer policy (Gregory et al 1992; Quinney 1989) and of even denying that it has a mandate for community development at all (Alberta Indian Health Care Commission 1989b). For this reason, and others, many people wonder whether or not the current transfer policy constitutes a viable model for Native health development or whether Native health services will be increasingly limited by this process.

Conclusion

The limits of biomedicine demand a pluralistic approach to health services. Health care options are needed to respond adequately to different conceptions of health and illness in society and to develop a more preventive and holistic approach to health. Community control is one mechanism by which health care options, or medical pluralism, may be achieved. Though the process of transfer to community control is complex and difficult, it is also necessary, particularly so for Native people who experience a lower level of health than the rest of Canadians, for whom health services are often inaccessible, and for whom demands for self-determination need to be met. The federal government has proposed a process for health transfer. The following chapter explores this process in greater detail.

CHAPTER 3

THE HEALTH PROGRAM TRANSFER INITIATIVE

Introduction

This chapter provides a discussion of Health and Welfare Canada's Health Program Transfer Initiative, or transfer policy. First, the chapter places the transfer policy in historical and political perspective through a brief review of Indian health policy since Canada's confederation; then, it outlines the policy's terms and conditions. The remainder of the chapter is devoted to an evaluation of the transfer policy, based on a set of criteria developed by researchers studying public involvement in health (Zakus and Hastings 1989) and modified by this author.

Background to the Policy

Early Phase

Since the Treaty Period (1850-1929), when provisions for health care services were included in some of the treaty agreements made between Native people and their colonizers (Frideres 1988), the debate has raged over the extent of the federal government's responsibility for Native health care in Canada. Only one of the treaty agreements, Treaty 6, specifies that health care services will be provided to Indians. These promises are found in its 'medicine chest' and 'pestilence' clauses:

> In the event hereafter of the Indians...being overtaken by any pestilence, or by a general famine, the Queen... will grant to the Indians assistance... sufficient to relieve (them) from the calamity that shall have befallen them. A medicine chest shall be kept at the house of the Indian Agent for the use and benefit of the Indians, at the discretion of such agent [15] (Young, T.K. 1984:257).

However, the signatories of the treaties claim that they also received verbal assurances from the Treaty Commissioners that their health needs would be met in exchange for access to their lands. They considered these verbal promises as solemn oaths which are to be taken as seriously as the written documents:

> Any serious review of the treaties reveals that the Commissioners, as evidenced by their own reports, testimony of the Elders and indeed terms of other treaties themselves, made very substantial commitments in the negotiations relative to health. Their 'outside promises' are as much a factor as what the Commissioners wrote on paper (Alberta Indian Health Care Commission 1986:3).

The significance of these promises has not faded over time; Treaty Indians today claim that the treaties form the basis for the government's legal fiduciary obligations to them. Furthermore, they claim that the terms of the individual treaties apply equally across all the treaty areas (Swampy Cree Tribal Council 1990b; Alberta Indian Health Care Commission, personal communication 1991) and that the written and verbal promises made by the Treaty Commissioners entitle them to comprehensive health care coverage to the same degree as these services are available to other Canadians (Alberta Indian Health Care Commission, no date; Indian Association of Alberta 1979; Swampy Cree Tribal Council 1990b). The treaties also dictate a direct and ongoing relationship between the federal government and Native people, which has been interpreted by many Native people to mean that they are entitled to deal directly with the federal government on matters which affect their health care services.

The Federation of Saskatchewan Indian Nations (FSIN) says that, though most Canadians view funds provided to Indians as contributions or loans provided to a disadvantaged segment of the population by a benevolent government, they are mistaken. Rather, these funds are the following:

> payments from one government, representing one of the signatories of an international Treaty (the Crown) to another signatory of that Treaty, the governments of Indian Nations. These payments are intended for such matters as defraying the costs of governing, operating and administering social, economic, educational and political institutions, planning and administering and delivering programs flowing from pre-existing, inherent rights affirmed in the Royal Proclamation of 1763 and called for by the international treaties between the Crown and Treaty Indians (FSIN 1988:19).

The federal government, however, has never formally acknowledged its treaty obligations to Indian people in the area of health. Differing interpretations of the Medicine Chest Clause of Treaty 6 have fueled this debate for years (Young 1984). The federal goverment claims it hitherto has provided health services to Indians on a moral and not a legal basis.

The whole question of who is responsible for Indian health is extremely debatable, as there is no clear legal mandate for the provision of health services to Indians. A Health and Welfare document entitled, "The Evaluation of Indian Health Services Report" (1990) admits that the wording of the relevant Acts is "ambiguous and seemingly contradictory" and does not indicate clearly which Act or clause should take precedence (in Adrian Gibbons and Associates 1992:45).

For instance, there is ambiguity as to whether Indian health is within federal or provincial jurisdiction. Two sections of the British North America (BNA) Act (1867) refer to Indians and their welfare. Section 91(24) assigns federal responsibility for Indians and land reserved for Indians, and Section 92(7) assigns provincial responsibility for establishing and delivering human services (Adrian Gibbons and Associates 1992; Scott 1993). As well, Section 73(1) of the Indian Act (1874) assigns federal responsibility over health by empowering the Minister "to prevent and control the spread of diseases on reserves, to provide medical treatment and health services, and to provide other medical and environmental services" (Adrian Gibbons and Associates 1992:45). Furthermore, federal jurisdiction is implied by the Canada Health Act (1984) which ensures that all Canadians receive insured hospital and medical services on the same basis. However, provinces differ in the services that they insure. Further ambiguity exists over who is responsible for Indian health because of jurisdictional divisions within the federal government, such as the division between Health and Welfare Canada and the Department of Indian Affairs, both of which have an impact on Indian health.

In 1945, responsibility for the provision of Indian health services was transferred from the Department of Indian Affairs to Health and Welfare Canada (Young 1984). It has been argued that this move was a step towards assimilating Indian health services into the Canadian health care system and eventually ridding the federal government of direct responsibility for Indian health. According to some observers, the integration of the two systems always has been the federal government's intent. Even Canada's Indian health policies may be interpreted to reflect this goal (Culhane Speck 1989).

Contemporary Phase

Since 1968, First Nations have been enrolled in Canada's universal health insurance program. The introduction of universal health care coverage for Natives provided another link between Canadian and Native health services. The government's presumed goal of integration is evident particularly in its policies and reports from 1969 onward; however, government support for separate and locally-controlled services also has developed during this period of time. The following review attempts to identify some of the sources of this ambiguity and some of the reasons why Health and Welfare's health transfer policy has been received cautiously or negatively in Native communities.

In 1969, the newly-elected Liberal government led by Pierre Trudeau introduced its "White Paper" report. The "White Paper" recommended that all Native programs be transferred to provincial control, thereby integrating them with the programs and services provided to the rest of Canadians. It also stated that the federal government was not formally bound or obliged to provide Indians with free medical services. Trudeau's goal in the White Paper was to create a 'colour-blind constitution,' in which policies and practices which discriminated against individuals on the basis of their ethnicity were to be eliminated (Kymlicka 1991). The 1969 White Paper proposed that "Indians no longer receive separate services from separate agencies, because 'separate but equal services do not provide truly equal treatment' (DIAND 1969, p.204)" (Kymlicka 1991:143).

The end result of implementing such a policy for Natives would have been assimilation into the mainstream of

Canadian society, at least legally, through the elimination of rights conferred to them via the BNA Act, the Indian Act and the treaties. The White Paper was rejected soundly by Native people. For instance, in 1970, The Indian Chiefs of Alberta published their 'Red Paper' or Citizens Plus which strongly criticized its assimilationist implications. The White Paper was withdrawn by the federal government; nevertheless, policies and reports with similar implications continue to be written.

For example, the Trudeau government's philosophy of integration and assimilation was still apparent in 1974 with the release of the 1974 Indian Health Policy. The central tenets of this policy are to deny First Nations the right to separate health services, to transfer responsibility for Indian health services to provincial administration, and to reduce spending on First Nations health care (Culhane Speck 1989). The Indian Health Policy of 1974 states, also, that there are no federal statutes compelling the federal government to pay for Native health care costs, suggesting the government's desire to relinquish this responsibility to the provinces.

1979 Indian Health Policy

Tensions mounted in Native and federal government relations throughout the 1970s. The federal government's and Natives' views on what kind of health care system was best for Native people stood in stark opposition to one another. The government maintained its stance on a unified and professionally-controlled health care system, while Natives searched for ways to achieve independent and locally-controlled health care (Culhane Speck 1989).

What could be interpreted as a change of heart on the part of the federal government appeared in the form of its 1979 Indian Health Policy. The policy reflected Canadian health promotion philosophy at the time (Young and Smith 1992), but it was also the federal government's response to fierce criticism from the National Indian Brotherhood (now the Assembly of First Nations) over government cutbacks to Non-Insured Health Benefits (Gilmore 1979). Non-Insured Health Benefits (NIHBs) are the health goods and services, paid for by MSB for status Indians and Inuit people in Canada, which are not covered under provincial health insurance schemes. (Incidentally, NIHBs are still the centre of much debate and dissatisfaction for Native people, as they continue to be subject to cutbacks and restrictions.)

The 1979 Indian Health Policy adopted the position that any improvements in Native health will stem from greater Native community involvement in controlling and being responsible for their own health services. The policy includes the following statement: "the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" but with strong support from Canadian society at large (Government of Canada 1979:Appendix 2). Health improvements are to be based on three pillars, namely:

> 1) "community development, both socio-economic development and cultural and spiritual development,"
>
> 2) "the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as an advocate of the interests of the Indian communities," and
>
> 3) the federal government's "active role in the Canadian health care system as it affects Indians," including "promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health" (ibid).

The Federal Government considered these three pillars to be the means to end poor health for Native people in Canada.

A federal government Discussion Paper in response to this policy affirmed the call for increased Native involvement in health care and acknowledged that Native people have unique health needs (Health and Welfare Canada 1979). In fact, Medical Services Branch admits in the Discussion Paper that their standard medical tools are not having an effect on controlling the health and social breakdown in Native communities.

It should be noted that, by this time, Native people had been involved in accessing resources to develop a wide range of health care projects on their own. These projects ranged from the development of community health centres and specific health programs to the development of health boards and committees, professional associations, and training programs for health professionals (Young and Smith 1992). Some communities also concluded 'contribution agreements' which enabled them to pay the salaries of nurses and Community Health Representatives (CHRs) and to administer medical transportation.

From 1979 to 1986

From the 1979 Health Policy to the announcement of the Health Program Transfer Initiative in 1986, government policy and rhetoric have suggested a political climate mainly supportive of community control and self-determination for Native people. However, the supportive policies and rhetoric have not always led to implementation and change. Furthermore, an exception to the supportive messages from the federal government came in the form of a government document (Task Force on Program Review 1985) which recommended cuts to Native programs. This report intensified suspicion among Native people that the government's underlying motives in transferring control might actually be the same as those which they identified in 1969 - assimilation of Native people into the Canadian health care system.

Preceding this report in the early 1980s, however, were two government documents supportive of Native self-determination in health. The Berger Report (Advisory Commission on Indian and Inuit Health Consultation 1980) and the Penner Report on Indian Self-Government (Special Committee on Indian Self-Government 1983) proposed increased funding and increased control to Native people. The Berger Report recommended methods of consultation to increase Indian and Inuit participation in decisions affecting their health care. As a result, funding for advocacy, consultation and liaison activities was made available to Native communities. The Penner Report identified Native health as an area of critical concern and as a prime candidate for local control. It recommended that Native self-government occur through three channels: constitutional entrenchment, legislative change and administrative reform.

The Penner Report made the important connection between Native health status and Native control, recommending that the Native right to self-government be firmly entrenched in Canada's Constitution (Gibbons 1988). The committee which prepared the report found that communities want to control the following areas: establishing priorities, coordinating planning and delivering health care (Special Committee on Indian Self-Government 1983). Furthermore, they would like to do this in their own way.

The pilot project for transferring control of Native health services began in 1982 when MSB introduced its Community Health Demonstration Program (CHDP). Under the CHDP, which ended in 1985, thirty-one communities were selected to undergo two-year demonstration projects. However, during this time, the federal government placed a moratorium on all other health transfer negotiations. The moratorium had a disruptive effect on communities whose transfer plans were already underway; and, the CHDP program has been criticized for this reason. The program itself was not without problems either, as illustrated by the Sandy Bay, Manitoba experience (Garro, et al 1986). These problems foreshadowed later experiences communities would have with the 1986 Health Program Transfer Initiative. Most notably, there was confusion among community members over the degree of community control attainable under the CHDP.

In 1985, the Sub-Committee on the Transfer of Health Programs to Indian Control was struck (Health and Welfare Canada 1986b). It consisted of Native people and MSB officials; and, its mandate was to propose policy options for Native control of health services. The committee recommended a developmental approach to health transfer and began a consultation process with Native leaders. In 1986, the Minister of National Health and Welfare, Jake Epp, sent a letter to all Chiefs inviting them to begin negotiations on the health transfer process.

Casting a shadow on Native and government relations at about the same time was the 'Neilsen Report' or Task Force on Program Review (1985), already mentioned. The Task Force was commissioned to review all government programs and to identify areas for reduced spending. Their report denies any serious federal government obligations to Indian people for their health and was like a flashback to the White Paper policy of 1969:

> There is no direct federal government legislative requirement for the provision of these services. In spite of cases brought before the courts, there is only some limited treaty responsibility to be exercised in the health care area. Services have been and continue to be provided on the basis of custom and federal policy (Task Force on Program Review 1985:330).

The report claims that Indians are entitled only to limited provisions by the treaties, despite the fact that the extent of treaty rights has never been settled by the Supreme Court of Canada and despite the fact that aboriginal and treaty rights were already recognized in a general way by the Canadian Constitution (1982) when the report was written (Alberta Indian Health Care Commission

1986). The Neilsen Report offered a restrictive interpretation of treaty right provisions and offered no guarantee of continued federal funding for Native health services. Though task force reports are advisory in nature only, they can have an effect on policy decisions and legislation and may reflect the political intentions of the government in power.

MSB invited Native groups to engage in the transfer process with the federal government soon after the release of this report, which led to confusion about the government's motives in engaging in health transfer. Was the transfer policy a means by which the recommendations of the Neilsen report could be implemented? That is, was it a means for the government to relinquish its responsibility for Native health care and legitimately reduce government spending on Native health? The Neilsen report continues to generate suspicion and caution on the part of Native people toward the federal government, leading them to wonder whether there is a hidden agenda behind the transfer of health services.

The move to transfer control to communities was, to a certain extent, in keeping with Native demands for self-government and self-determination, and therefore was heralded as a positive step for Native peoples; but, it also has been cause for concern that the government is merely "dumping" responsibilities onto Native communities that they may not be prepared to handle or pay for. This sentiment exists despite MSB's claims that they have adopted a developmental approach to transfer based on the concept of self-determination in health and that they are prepared to respond to the individual circumstances of each community (Health and Welfare 1988a and 1989a).

Terms and Conditions of Transfer

MSB's Stated Goals

MSB's health transfer program is based on Keith Penner's recommendation in the 1983 Special Committee Report on Self-Government for administrative reform (Health and Welfare Canada 1988b). Health transfer, then, entails the transfer of administrative control to Native groups. The policy's goals, according to MSB, are as follows: to enable communities

> to access resources to design their own health programs, to establish services, to allocate funds according to community health priorities and to strengthen the accountability of Band leaders to Band members (Health and Welfare 1988a:3).

The relationship between the federal government and Native groups fostered by this arrangement is promised to be on an equal footing, "more like that of one government to another rather than of an agent administering federal government programs" (Health and Welfare 1989a:4-1).

Each community decides whether or not to embark on health transfer. Communities who decide to retain any or all of MSB's services will not be disadvantaged by their decision, according to MSB. That is, MSB promises that the level and quality of services provided to bands who choose not to transfer will not diminish as a result of signing a transfer agreement (Health and Welfare 1988a).

Programs Eligible and Ineligible for Transfer

Only existing health services and funds for those services are transferrable. Existing services which are eligible for transfer include community health services, environmental health services, prevention and counselling programs, the services of medical professionals and hospital services. Community health services include nursing, Community Health Representatives, health education, nutrition, mental health, dental services not classified as Non-Insured Health Benefits, and medical and dental advice and assistance. Transferable funds include an administrative and management component which represents resources in zone and regional offices. These funds contribute to the community but are not readily apparent. A detailed funding formula breaks these resources down on a per capita basis to the communities (MSB, personal communication 1991). Health transfer does not allow for the enrichment of health services, though MSB officials claim that it does allow for flexibility in allocating resources (ibid.).

The following responsibilities are not available for transfer to Native communities: clinical training and outpost training for nurses; the Indian and Inuit Health Careers Program; the School of Dental Therapy; research and development activities under the National Native Alcohol and Drug Abuse Program (NNADAP); and other centralized training programs. MSB feels that they do not "lend themselves easily to community-based transfer arrangements," though they may be considered eligible for transfer in the future (Health and Welfare Canada 1989a:5-2).

The most important non-transferable programs are the Non-Insured Health Benefits (NIHBs). NIHBs include prescription drugs, medical supplies and equipment, optometric services and eyeglasses, dental care, prosthetics, health insurance premiums and co-insurance fees, and medical transportation (Health and Welfare Canada 1990e). Some NIHBs, such as medical transportation, are administered by communities under existing contribution agreements. MSB assures communities that these aspects of NIHBs will not be affected by the part of the transfer policy which considers NIHBs ineligible for local control (Health and Welfare Canada 1989a). The fact that most NIHBS are ineligible for transfer forms the basis of major criticisms of the transfer policy.

The Transfer Process

The transfer process is divided into three stages: pre-transfer planning, transfer negotiations, and transfer implementation. Pre-transfer is a two-year period of funding designed to support communities in preparing an extensive Community Health Plan (CHP) and in setting up local health authorities. The CHP forms the basis of the transfer negotiations between the community and MSB. In preparing to meet these requirements, communities undertake health needs and health status assessments, hold community awareness workshops and train health committees (Postle and Moffatt 1988). The CHP "outlines what health services are most needed, how these services will be run and how health care money will be spent" (Health and Welfare Canada 1990a:5).

It includes mandatory programs as well as programs the community wishes to develop. The mandatory requirements include an emergency response plan, a comprehensive audit and annual report, and periodic evaluation exercises. Funds for pre-transfer are available on a one-time basis only; and, pre-transfer requirements must be met before communities can begin transfer negotiations, whether or not they choose to take advantage of the optional two-year funding period.

Community proposals for pre-transfer funding are assessed by MSB officials at regional, zone and national levels for their feasibility. Transfer negotiations take place between community health authorities and regional MSB officials once pre-transfer requirements are completed to MSB's satisfaction. Transfer implementation begins once the community is "ready to design and manage its own health programs through a transfer agreement" (Health and Welfare Canada 1989a:6-1).

Though the Minister of Health and Welfare retains the responsibility to intervene in the case of an emergency or breakdown in the health program or Indian health authority, MSB claims that every effort will be made to ensure that such intervention is limited to the minimum amount necessary to solve the problem and maintain public health and safety (Health and Welfare Canada 1989a).

Analysis of the Policy

The Health Program Transfer Initiative now will be examined in terms of its ability to foster the development of locally-controlled services and health care options for Native people. The following criteria, modified from a list of criteria provided by Zakus and Hastings in their literature review on public involvement in health (1989), will be used:

a) Is a significant degree of authority, power, control and responsibility conferred to communities through transfer?

b) Does MSB prepare communities for transfer?

c) Are health professionals and bureaucrats supportive of the transfer process?

d) Is the development of health care alternatives fostered by this transfer process?

e) Does the transfer policy have the potential to improve Native health?

Degree of Control Transferred

Though the Penner Report recommended that self-government be achieved through constitutional entrenchment, legislative change and administrative reform, so far the health transfer process among First Nations involves only the transfer of administrative control. Keith Penner refers to transfer as a way to 'stretch' current legislation, the Indian Act, without actually changing it (Special Committee on Indian Self-Government 1983). While administrative control is one step in an incremental process, it will not necessarily encourage Native people to become involved in their health care if they feel that their decisions can be overturned easily or if they feel that they are limited to inheriting the government's administrative structure because of the restrictive terms and conditions of the transfer policy.

The Assembly of First Nations, the national political body which represents status Indians, also criticizes the limited amount of control being afforded by health transfer, observing that the "power to apportion budgets, determine mandatory programs and set standards for health services on reserves remains in the hands of the federal government" (Sherlock 1990). Medical anthropologist John O'Neil has observed this situation in the North, whereby community health committees serve only an advisory function and local involvement in primary health care exists only in support roles (O'Neil 1986). Certainly, the federal government cannot be expected to relinquish all control while continuing to fund Native health care. And, undoubtedly, some Native communities desire assistance in running their health services. However, people are not encouraged to become involved in community programs and services if they cannot make meaningful and substantive contributions to them. Furthermore, by allowing only peripheral involvement of Native people in basic services such as health care, the federal government contradicts its own claims in support of Native self-determination and self-government and perpetuates a colonial-style relationship with Native people.

Achieving a link between health transfer and self-government is an objective shared by many First Nations (Union of Ontario Indians and the Assembly of First Nations 1991; Adrian Gibbons and Associates 1992). The lack of such a link has been identified as one of the major problems with the transfer initiative. For instance, in 1987, Greg Smith, representing the Alberta Indian Health Care Commission at a health transfer conference in Montreal, endorsed the concept of transfer

> insofar as it may become part of a recognition of Indian self-government by the federal government and insofar as it includes sufficient resources to enable Indian communities to achieve levels of health and well-being equivalent to those enjoyed by the non-Indian communities of Canada (Smith 1987).

Echoing this call at a subsequent transfer forum in 1989, Georges Erasmus, then Grand Chief of the Assembly of First Nations, expressed his support for First Nations engaging in transfer as long as the federal government recognized Native self-government and MSB recognized the right of First Nations to determine the scope of their own transferred health care programs (Union of Ontario Indians and the Assembly of First Nations 1991).

Administrative requirements and program and funding restrictions of MSB's health transfer have prevented this link from being forged securely. Though MSB promises that health transfer will strengthen the accountability of band leaders to band members, critics have noted that the requirements of health transfer are making Native leaders or health authorities more accountable to the Minister of Health and Welfare than to their own communities (Postl and Moffatt 1988).

Commenting on the process of administrative transfer to Indian communities in general, Sally Weaver, a political anthropologist specializing in the study of federal Indian policy, says that the process not only is inadequate, but it is creating more dependence on the federal government because of its complex administrative and bureaucratic requirements (Weaver 1990). Indeed, health transfer requirements are making some Native people feel as though they must "jump through hoops" even to complete the pre-transfer stages. Others, frustrated by the extensive requirements, have accused the federal government of designing a project geared to fail in order to prove that Indian people are not capable of managing their own services (confidential interview).

To be fair, it must be said that although some groups have found pre-transfer requirements nearly impossible to satisfy, others have found them at least partly beneficial.

For instance, the William Charles Band of Montreal Lake, Saskatchewan, used the results of their community health assessment to raise community awareness of health problems. This motivated community members to improve their health status and allowed the band to pinpoint areas for health development (Four Worlds Development Project 1990). The Nuu-Chah-Nulth Tribal Council in British Columbia, who signed a health transfer agreement in 1988, also found the process of completing community health assessments and undertaking community-wide surveys to be useful. Previously unidentified health problems are being discussed now, particularly in the area of mental health (Reed and Watts 1990).

However, members of the William Charles Band attribute their success in improving community health more to a reorganization of their health care services and less to transfer itself, though they admit that without the impetus transfer provided, these changes might not have taken place (Bird and Moore 1990). Similarly, the health problems identified by the Nuu-Chah-Nulth Tribal Council through transfer are being met only partly through transfer's funding arrangements (Reed and Watts 1990).

Gains have been made with transfer, and gains have been made in spite of transfer requirements and a limited amount of time and money with which to satisfy them. For instance, the Swampy Cree Tribal Council (SCTC), a federation of six First Nations from northwestern Manitoba, was able to establish a community health board and a by-law under a section of the Indian Act which enables the band to "exercise its authority to regulate health on-reserve" (SCTC 1990a:5), despite having to meet extensive bureaucratic transfer requirements. These requirements included the "preparation of documents and proposals every six months or on a yearly basis" which detracted from "limited time and funds allotted to pre-transfer planning with communities" (p.6). Members of the Tribal Council say that they entered the transfer process with their "eyes wide open" and that they feel competent to look after themselves in their dealings with government. Not every community feels so prepared, however.

A lack of adequate funding is another impediment to the transfer of significant power and control. MSB claims that transfer will enable Native people to access resources to design their own health programs (Health and Welfare 1988a). MSB, however, transfers only funds for existing services. This process does not allow for program enhancements. For communities in which services and resources are already minimal or substandard, health transfer has been described as the transfer of an 'old grey mare' to the community (confidential interview). If current resources were producing a level of health and well-being in Native communities on par with non-Native communities in Canada, then transfer would be more acceptable to Native groups.

As it is, many leaders are concerned that current funding limits will not allow them even to fill the gaps in their health services (Postl and Moffatt 1988), let alone design and develop new services. For instance, during their initial review of the policy, the Onion Lake Band of Saskatchewan expressed concern over the fact that MSB was prepared to transfer only funds based on current expenditure levels (Gibbons 1988). This band, and other groups, are wondering how they will manage in a few years when buildings have deteriorated and are in need of repair and when costs of living have increased. One British Columbia community, which has reached the end of its three-year agreement with MSB, feels that it has outgrown transfer. The health services its members wish to provide, or are required to provide, exceed current funding levels.

A more specific funding concern is the financial support provided to local health boards and committees. First Nations have had a difficult time establishing local health authorities such as boards and committees, which are seen as crucial to the success of community-controlled programs. They are allotted only $35.00 per member per monthly board meeting (Union of Ontario Indians and the Assembly of First Nations 1991). First Nations at the Health Transfer Forum held in Toronto in 1989 recommended that MSB provide more resources for Indian health board development for all First Nations, whether or not they are engaged in MSB's transfer process (ibid.).

Alberta Chiefs also recently resolved that MSB should make funds and resources available outside of the transfer initiative to communities who wish to pursue their own community development activities (Alberta Indian Health Care Commission 1990:5). Though federal funding is not boundless, MSB would be wise to heed the Chiefs' resolution and introduce greater flexibility into funding Native health development. A lack of funding flexibility on the part of Health and Welfare is evident in its rejection of independent funding proposals for community health development. A transfer proposal developed in 1985 by Manitoba Natives and staff at the University of Manitoba representing 27 Manitoba bands (Postle and Whitmore 1988), and a proposal developed by members of the Little Red River Band of northern Alberta in conjunction with a sociologist from the University of Alberta (Little Red River Band Tribal Administration 1988), were both rejected by MSB.

Whether or not these were 'good' proposals, the experience of rejection is an inhibiting one for the people involved and would seem to discourage future community involvement in health activities.

Inadequate funding of local health services through transfer sometimes forces Native communities to rely on provincial programs and services to fill the gaps in their health care coverage. A Native health administrator pointed out to me that once Native communities start relying on provincial programs, and "unless the Chiefs do something about it on a treaty issue stance," eventually the recommendations of the White Paper and Neilsen Report will be realized and "we'll all be under provincial jurisdiction" (confidential interview).

Another serious limit to the devolution of significant authority, power and control is the fact that not all existing health services are eligible for transfer. These include the Non-Insured Health Benefits, described previously, which are seen as important features of any health care system (Postl and Moffatt 1988). As one Native Health Director expressed to me, "You can't transfer half of a health care system." The hazard in leaving the control and administration of NIHBs to the MSB is that decisions regarding the provision and extent of these services are being made by the federal government without Native input and consent. Cutbacks to NIHBs are seriously affecting the quality of health services that Native people receive. For instance, financial limits on dental, optical and prescription drug coverage have forced people to make up the difference out of their own pockets. If they are on welfare, or are 'low-income,' as many Native people are, they will not be able to afford these goods and services. Usually people do not realize that new restrictions apply until they are told at the health center or clinic that the medication they need, for instance, is not on the list of available drugs (confidential interview). Another concern for Native people regarding NIHBs is that eventually the administration of NIHBs will be transferred to provincial service providers, and the federal government's goal of provincial jurisdiction for Native health will be realized. In Alberta, Blue Cross, rather than MSB, is already managing health care billings for Native health.

The fact that certain programs are mandatory in transfer also has been criticized. The Alberta Indian Health Care Commission views the federal government's insistence on mandatory programs as a barrier to self-determination in health. The mere existence of mandatory programs, such as an immunization program, are considered "paternalistic put-downs," especially since the provinces do not have immunization as a mandatory program (Alberta Indian Health Care Commission 1989b). Another mandatory program of the transfer policy is the emergency response plan. Though emergency response plans would be very useful for remote communities which rely on distant hospitals and facilities for emergency services, they are difficult for groups to design and implement without having adequate funding or training to do so. Gibbons, who has worked with the Onion Lake Band in Saskatchewan on health transfer, notes that the requirements of the Community Emergency Response Plan would be "beyond the planning capacity of most municipal governments in Canada" (Gibbons 1988:79). Either such restrictions should be lessened, or MSB should be prepared to support communities in the preparation of these plans.

Does MSB Prepare Communities for Transfer?

People may resist transfer because of a low level of awareness of health issues. This seems to be the case according to two Native informants, both involved with Native health issues on a professional basis. They say that community members are not aware of the state of their current health services and so have little means to determine what kinds of services they need or want in a health care system. Clearly, the success of health transfer will depend to a large extent on how prepared communities are for the process, including how well trained they are to assume various new jobs and responsibilities.

To inform communities of transfer issues, the Health Transfer Newsletter was established by Medical Services Branch. This quarterly newsletter is brief and not particularly in-depth, but it presents major issues and developments in transfer, such as information on conferences, Native health career opportunities and the transfer process itself. Medical Services Branch encourages feedback on this newsletter from First Nations people.

The newsletter, however, is not something that the average person would read. Furthermore, it reflects a government and not a Native perspective on health transfer. In fact, one of the factors which interferes with effective communication between Medical Services Branch and the community, identified by a Health Steering Committee from the Union of Ontario Indians, is "the preference of the bureaucracy to distribute information in print form in contrast to the community's preference for oral communications" (Castellano 1988:35). Though some Native health committees and community leaders have found it informative (Adrian Gibbons and Associates 1992), the Health Transfer Newsletter paints a very simple and optimistic picture of the transfer process. Obviously, the federal government is interested in encouraging bands to enter into this agreement. Native/government relations over the years have created a degree of caution and cynicism among Native people, however, which surely will avert any possibility that Native expectations will be raised unduly by the newsletter.

Avenues other than the newsletter are needed to communicate communities' experiences of transfer. Two national, Native-organized transfer forums have been held since 1987; however, there are few formal mechanisms for transmitting this information to communities on a regular basis. The Alberta Indian Health Care Commission serves this function as a regional health board for the province; and, the Assembly of First Nations Health Committee serves this function nation-wide. Their small staff sizes, however, surely limit their effectiveness in this matter. The Alberta Indian Health Care Commission holds regular meetings with Native Health Directors in the province, which is a positive step in creating information exchange among communities on technical matters relating to health; however, the Commission has expressed concern that they do not receive information from MSB in time to respond effectively or to have direct input in decision making (personal communication). Communication and information systems clearly need to be enhanced at both the local and federal levels. MSB should not expect people to engage in transfer without keeping them well informed.

Training is another area of contention surrounding health transfer; that is, while Native communities may be willing to assume control, they may not possess all of the skills required to do so. Transfer Training Programs available through MSB (Health and Welfare 1990c:2), and affirmative action and health career programs, are qualifying more Native people for positions of influence within MSB and the health care system. However, MSB funding for training is limited. In fact, they encourage Native communities to apply for funding from as many other agencies as possible to supplement the training resources they receive through MSB (ibid.). Training Native people so that they may be able to assume professional, paraprofessional and management roles is vital and should be a prime area targetted for funding by the federal government if it is sincere in its efforts to enhance community control. For the present, the majority of health personnel are non-Native and must be recruited to work in Native communities. This responsibility falls to the communities under transfer, not an easy task, especially for communities in remote regions (Postl and Moffatt 1988:2419).

Degree of Professional Support for Transfer

Through the transfer process, Native people presumably are in the position to restructure health care programs in ways which best suit their communities and best address their health problems. These changes will incorporate (and already have incorporated) Native managers, health committees, health boards, paraprofessionals, Native nurses and physicians, and in some cases, traditional healers. The dominance of the federal bureaucracy and of the medical profession itself is being challenged by this arrangement. New programs and services will not involve bureaucrats and health professionals to the degree they once did. The formal health system may be reluctant to encourage and accommodate extensive public involvement.

Regional offices of MSB across Canada, and staff led by a Regional Transfer Coordinator, are responsible for providing consultative services to Native bands about transfer. MSB claims that health transfer negotiations will be made in the spirit of partnership. The process of health transfer, however, will still pose a challenge for Native communities who will be receiving greater control and for MSB personnel and health professionals who will be relinquishing it. "This requires flexibility to adjust to changing relationships, the acquisition of new and different skills; and for some, even withdrawal from active participation in the delivery system" (Tupper 1988:338).

For Marguerite Keeley of Medical Services Branch, Program Policy and Planning Directorate, transfer will be as much of a change for the Branch as it will be for the community.

> The Branch has always been the expert. We have always gone out and helped people, by curing them or treating them or counselling them. That's not our role anymore. So we're really turning ourselves around, as well as the communities are turning themselves around. We have to help each other, I guess (Four Worlds Development Project 1990:36).

Because transfer is an optional process for bands, MSB's role will be retained in those cases in which bands do not wish to take control over health services (Health and Welfare 1988a). This situation means that health program managers will have to play several different roles simultaneously (Tupper 1988). Flexibility and adaptability, therefore, are essential qualities of MSB personnel.

It is important to ask, however, whether services really will continue to be provided at the same levels and whether MSB will be able to meet its residual responsibilities adequately with the restructuring of MSB that continually is going on. MSB recently has reduced the number of regions and regional offices across Canada, and this trend frightens some Native health workers. Actually, there is no consensus among First Nations on what the residual role for MSB should be. First Nations views range from support for complete noninvolvement of MSB, to support for maintaining its services indefinitely (Adrian Gibbons and Associates 1992). Residual responsibility is closely tied to treaty rights to health care and the fiduciary responsibility of the federal government to provide health services to Indian people (ibid). That is, if MSB disappears, how will these rights and responsibilities be met fully?

To return to the criterion in question, the extent of professional support for health transfer, it is important to reflect on the comments already made regarding the levels of control, funding, training and time available for transfer. These limits reflect a limited degree of support for the transfer process from the government, despite whatever good intentions individual MSB personnel may have.

Native people also are feeling intense pressure from MSB to transfer, even though they may not be ready or may think that the transfer policy is inadequate. For instance, one Health Director regularly receives information from MSB on the attractive salaries that a Health Director will make upon transfer, "dangling the dollars" as an enticement. Despite the temptation, this individual feels it is necessary to wait until the community is well informed before going ahead with transfer negotiations. Communities also are feeling pressure because they fear that Native health services will continue to erode and that they should transfer now before it is too late. For this reason, many people feel that transfer is being forced on them.

The belief that the federal government is trying to get rid of Indians one way or another is strong in Native communities: "It's something that has been ingrained in my mind from my own parents, grandparents, people in the community, older people," one informant revealed. Another informant, who shares this view of the federal government, feels that MSB is pushing transfer so that communities will sign the agreement before they understand its negative implications:

> You sign a document saying that this is all you get, so that when you wake up to the reality that you can empower yourselves, you can't come after them.... They're going to find a way, an ultimatum. If you aren't going to transfer, we're going to do this to you, or something. It's coming (confidential interview).

Because of this sentiment, some Native health administrators feel committed to taking "the bull by the horns" and making clear demands to MSB over what it is that communities want in their health services. "I think we've got to do that before everything is taken away," said one Health Director (confidential interview). At the same time, however, they feel responsible to wait until community members understand what transfer is all about.

MSB will need to work hard to shed the federal government's image of antagonist and to provide the necessary support for health transfer to work. By chance, I was interviewing a health administrator on a day that MSB paycheques to health center staff were late. The frustration in the air from all of the angry phone calls he was receiving was almost palpable. Apparently, paycheques to health center staff often arrive late. This is just one small example of how support from MSB will be felt in Native communities.

Support from health professionals and consultants also will be necessary. A significant omission from the transfer policy is its failure to discuss the relationship between First Nations and health care professionals (Culhane Speck 1989), except to say that bands will be able to hire and recruit their own doctors and nurses. The relationship between service providers and recipients is an important one and deserves to be given a great deal more attention in transfer arrangements.

Certainly, the qualities of flexibility and adaptability which MSB needs to demonstrate will be required of health professionals as well. One Native health administrator, with whom I spoke, remarked on how the nursing staff at her community's health center is resistant to the idea of obtaining community consent on health issues before decisions are made. This situation illustrates the need for sensitivity among health professionals to community norms. Health professionals, moreover, should be willing to take direction from Native staff members if their intention is to support Native communities in the transfer process. The same kind of cooperation is required of outside consultants and researchers.

Prospects for Developing Health Care Options

The health transfer policy has a limited ability to foster the development of health care options outside of the services that Native communities presently receive. This limitation exists largely because of the restrictions already mentioned, including the MSB's intent to transfer existing services and administrative control only, its restrictive terms and conditions, and its inadequate financial support for training which would prepare communities for the task of running their own health services. The potential for health care options to develop under the current transfer policy is also limited by the lack of a mandate for broad-based community development or provisions to link health care services to other social service agencies and programs at the federal and local levels.

The experience of the Gull Lake Band with the pre-transfer process confirms the need for broad-based community development to improve health. Health problems identified by the community included "limited economic development, austere community conditions and deficient housing" (Gregory, et al 1992:217). Community development, which is necessary to address these problems, is not part of the health transfer policy. Granted, MSB could not be expected, single-handedly, to address these problems. Nevertheless, a "health transfer policy that does not account for the presence of other relevant governmental agencies and the need for economic and community development is restricted in its ability to effect change" (ibid.). Henry Quinney, Chairman of the Alberta Indian Health Care Commission in 1989, implored government to demonstrate a commitment to community development in health transfer:

> Schooling, economics, job creation, environment, housing, recreation, facilities and infrastructures are all part of community development and cannot be separated from the whole to suit a narrow bureaucratic definition of health...[community development] does not exist in harmony with the Federal Government's concept of self-government, or with the present MSB thrust to transfer health programs to the communities. There is no relationship (Quinney 1989:9).

Collaborative efforts among MSB, the Department of Indian Affairs, and Native communities are needed to develop health care options which will address Native health problems related to poor living conditions. MSB, surely, could include a commitment to broad-based community development in its health transfer policy without being expected to assume sole responsibility for it.

Another limit to the development of health options within the confines of the health transfer policy is the policy's inattention to the importance of Native culture and traditions. Stout, president of the Indian and Inuit Nurses of Canada, says that a serious problem with the transfer initiative is "the perception of many policy makers that indigenous traditions are to be peripheral to the process" (Stout 1991:1). In fact, according to Stout, "it is Native institutions such as elders and extended families which heal community rifts and encourage popular participation" (ibid.:2). Though Native people feel that these institutions should remain outside of MSB's control, and rightly so, they need to be recognized as essential to the process of Native health development and need to be supported. A member of a British Columbia band says that, because they have been expected to provide quality health care on a "shoestring" budget, they have not yet been able to innovate and incorporate their philosophy of holistic health. Eventually, they would like to include an Elders Council, traditional healing practices and a Native nutrition program in their community health services (confidential interview).

Jurisdictional limitations also restrict the development of innovative solutions to health problems in Native communities. Indian health jurisdiction was an area of concern at the 1989 Health Transfer Forum (Union of Ontario Indians and the Assembly of First Nations 1991). Though health transfer allows bands to pass health by-laws, via the Indian Act, these bylaws must not be inconsistent with the Act. Health Transfer Forum recommendations include that First Nations move, therefore, toward self-government and toward establishing their own health standards.

Prospects for Improving Native Health Status

Health development will be a long-term process. Simply raising the overall level of awareness of health issues in Native communities will take time. So, it is difficult to determine health transfer's prospects, alone, of improving Native health. Nevertheless, some improvements in Native health have been attributed to the policy. For example, the William Charles Band, which signed a transfer agreement in 1988, has been able to provide more comprehensive and accessible services on reserve as a result of health transfer. Because of an increased sense of community responsibility for health, and because of improved health services, community health has improved (Bird and Moore 1990). As mentioned previously, however, the William Charles Band cannot attribute improvements in health status solely to health transfer.

The Swampy Cree realize the limits of transfer in being able to improve Native health:

> We have learned that pre-transfer planning is just a starting point in the process of community control of health.... Imagination is necessary to create and focus on issues which have been unforseen by the federal government in its policy of health transfer...It is not a solution to all the health problems we face in the communities. It is only administrative control. Once that fact is accepted, we can get along with pursuing other objectives to resolve our health needs in other ways (Swampy Cree Tribal Council 1990a:8).

Alternative approaches to MSB's health transfer policy, undoubtedly, are required for substantial improvements in Native health to occur. Hopefully, the federal government and Native communities will be able to resolve their conflicts to the extent that alternatives may be developed.

Conclusion

The federal government acknowledges that a greater degree of participation by Native people in the delivery and control of health care services is necessary; and, it does acknowledge, in the 1979 Indian Health Policy, the importance of a three-pronged developmental approach- socioeconomic, cultural and spiritual - to eliminate the causes of poor Native health (Government of Canada 1979).

However, the health transfer policy is limited in its ability to meet these needs; and, few avenues exist outside of the current transfer policy for Native people to achieve local control over the organization and delivery of their health care and to procure the resources necessary to develop health services. Furthermore, the jurisdictional ambiguity over Indian health and the failure of the federal government to acknowledge formally a legal or treaty responsibility to Indian health has intensified the strained relationship between First Nations and the federal government.

In asking whether or not the transfer policy represents a new direction in Indian health policy, Culhane Speck reminds us that the transfer policy and all First Nations/ federal government relations

> take place within a context that is fundamentally shaped by the conflict between First Nations' assertions of their inherent right to self-determination and the federal government's denials of, or attempts to limit, these rights. In the health field this conflict has been reflected in the federal government's consistent attempts to eliminate whatever differences exist between the health services available to First Nations and those available to non-Natives, and First Nations' consistent demand that the federal government recognize their right to distinct health care services (Culhane Speck 1989:188).

The transfer policy reflects the government's refusal to compromise on its position of a single health care system, she says. That transfer has not been accepted wholeheartedly by Native people and, in fact, has faced harsh criticisms by Natives and non-Natives alike, suggests that a gap between federal government and Native notions of health care, community control and self-government still exists. Policy-making, after all, is not a value-free process (Hill 1986; Weaver 1985). When the culture and social structure of the policy-makers differ from that of the communities for which the policies are intended, problems naturally arise.

Though several communities have entered into the transfer process with MSB (79 pre-transfer projects representing 244 bands, and 14 signed transfer agreements representing 55 bands, as of September 1991 (Adrian Gibbons and Associates 1992)), this health transfer represents a restrictive approach to Native health development, at least at this stage in the process. If MSB's transfer policy is unsuitable, then what are the options? It is clear that constitutional, legal and treaty issues need to be resolved. It also is clear, however, that many Native communities are not willing to wait for constitutional, legal and treaty issues to be settled before they partake in Native health development efforts.

Since this thesis is not geared to solving overarching constitutional and legal issues, and it would be presumptuous to think that it could, the next chapter focusses instead on practical issues which need to be addressed for Native health development to proceed in the meantime. I propose that compromises, which strike a balance between the extremes of assimilation of Native people into the Canadian health care system and their complete separation from it, need to be reached on each of these issues. Together, these compromises constitute a mid-range approach to Native health development. I believe that it is within this middle range that health care options, or medical pluralism, for Native people will be discovered.

CHAPTER 4

THE RANGE OF OPTIONS

Introduction

As already mentioned, there is a range of opinion on the direction that Native health services should take and on the degree of control that Native people should have over their health care services. One end of this range or continuum represents an assimilationist perspective, whereby Native health services are absorbed into the biomedically-dominated Canadian health care system and Native people have no control over the kinds of services they receive. The other end of the continuum represents a separatist perspective, whereby Native health services are dominated by traditional Native medicine and Native people have absolute control over the design and delivery of those services.

The disadvantages for Natives of receiving only government-controlled and standard biomedical health services are many: these services do not adequately meet their health needs; they are not always sensitive to Native culture; they do not encourage Native people to become involved in their health care; and, they do not meet Native demands for self-government. On the other hand, the disadvantages of having a completely community-controlled health care system dominated by alternatives to biomedicine, including traditional Native medicine, are the isolation and marginalization from the biomedical system and anything useful it has to offer and the huge burden of community responsibility that total control entails. The middle of this range strikes a balance between these extremes. It is characterized by the existence of locally-controlled and designed health care services, which may or may not be based in traditional medicine, and which interface with government and professional health care services but are not dominated by them. Achieving this balance requires that compromises are reached on a number of issues.

This chapter identifies some of these important issues and the compromises which might be reached within them by Native people, the government and health professionals. It does not attempt to integrate these compromises, or mid-range approaches, into a single model or present them as absolute requirements to solving the problem of Native health development. The unique needs of each community will render a rigid model of Native health development artificial and useless. However, the literature and my interview material reveal recurring themes and recommendations which, at least, should be considered by those involved in Native health care. Before exploring mid-range approaches to the problems involved in Native health development, a brief description of the extreme options is in order.

Assimilation

From this perspective, a single, biomedical and government-run health care system should exist for all Canadians. For the sake of administrative convenience and costs, it would be preferable if Native people were "ordinary Canadians" who used the same health care services as everyone else. This approach to the provision of health services is assimilationist in nature and ignores the significance of cultural and socio-economic differences between members of the population in determining health needs and developing appropriate services in response to those needs. This position denies the fact that Native communities, for instance, may require different kinds of health services than non-Native communities and may be in the best position to determine what those services should be.

Attempts to assimilate Native people into mainstream, Canadian society have proven disastrous for Natives. The social and psychological disorganization caused by the compulsary enrollment of Native children in residential schools serves as a prime example of the damage done to Native people by assimilationist policies. As one informant said, "There is a lot of healing to be done across the nation." The ultimate failure of assimilationist policies and practices, however, may be seen in the survival of 'Native' traditions and beliefs.

Separation

The logical opposite of the assimilationist approach is a separatist approach, whereby Native people have complete control over all decision-making pertaining to their health care and reject biomedicine in favour of health care alternatives such as traditional Native medicine. Though many Native people support the notion of complete community control over health care, I did not encounter any support for the complete rejection of biomedicine. Native people know that complete autonomy from biomedicine would be impractical, separating them from a valuable form of health care. Therefore, this end of the continuum exists mainly for conceptual purposes. Changes, nevertheless, are needed in order to promote greater Native autonomy in health so that rejection of the Canadian health care system is not seen as the most desirable option to Native people.

The Middle Ground

What is the balance or middle ground between a government-controlled and integrated health care system for Natives and their separation from this system? What mechanisms exist outside of MSB's health transfer policy, which is too close to the assimilationist end of the continuum, to develop community-designed and controlled health services? What, in fact, do Native communities need and want in order to establish successfully their own health authorities and services? What is the role for government in this process? How can compromises which accommodate diversity be reached?

According to Boldt and Long (1985), in their discussion of the conflicts between tribal traditions and European-Western political ideologies, the challenge that Native communities face is to develop models of self-government that prove palatable to the federal government without sacrificing "internal self-determination" or "compromising fundamental traditional values" (Boldt and Long 1985:342). Compromises must be reached within communities, as well, to achieve the kinds of health service arrangements that community members want.

At least six overarching (and overlapping) issues, or problem areas, have emerged from my data. They are community control; funding; health care orientation; community involvement; Native traditions; and professional and outside support. I will use these issues to frame my discussion, which is in no way exhaustive, of what is needed to foster Native health development and the development of health care options or medical pluralism.

Community Control

How involved should the federal government be in Native health care? The range of opinion within this issue extends from one extreme, whereby communities should be solely accountable to the Minister of Health and Welfare, to the other extreme, whereby Chiefs and Councils should be accountable only to their community members. To date, Native health policies have been designed by non-Native bureaucrats and health professionals for Native people and have tended to limit community control, the quality of health services and ultimately improvements in health. There has been little upward flow of information from the communities to governments that has made much of a difference to the way community health services are run.

Clearly the issue of community control is multifaceted; and, the degree of control granted to Native communities will depend on a number of criteria. For instance, the fact that Native communities are financially dependent on the federal government limits the degree of control they may expect to attain. (I will discuss the financial aspects of community control in the following section on funding.) As well, their level of preparedness for taking on all of the responsibilities of self-government will determine the degree of control they will be granted at one time. Finally, Native community control will be limited by a general reluctance in Canadian society to extend special rights and privileges to certain segments of society.

The level of community readiness for transfer is a valid criterion for determining how much control communities should have over their health services. This degree of preparedness, however, should not be decided solely by Health and Welfare Canada or by health professionals in the community. Community members, themselves, need to assess their ability to manage their own health services and be allowed to increase their expertise through experience with local control; expertise does not necessarily have to precede control in all areas. Communities, however, should be realistic in determining how much control they can handle at one time. We know from the discussion of MSB's transfer policy that enough control must be transferred simply to encourage people to become involved at all. Too much control and responsibility at once, however, might leave communities feeling overwhelmed. The federal government, therefore, needs to loosen its grip on Native communities, but, at the same time, support them if they require and request outside assistance.

One problem which suggests that the federal government retain a degree of control is the existence of sociopolitical divisions within Native communities which can lead to the unfair distribution of funds, services and jobs. The existence of family factions make self-government and a lack of accountability of Chiefs and Councils to a higher authority seem like a frightening prospect for some people. Making reference to the transfer of administrative control for social services on reserves from the federal to the local level, a resident of Sucker Creek, Alberta comments: "Right now, it's not what you know, it's who you know....If you're related to someone on the (band) council, you get what you want and then some....But if you're not, forget it" (Moysa 1991:A6). Internal community divisions suggest the need for some kind of arbiter when community members feel they have no other recourse against discriminatory politics. However, there is a risk that involving a third party arbiter might threaten community autonomy and the integrity of internal political processes.

One problem with devolution in the North, that also suggests the need for some kind of arbiter, is the power struggle that has developed between territorial, regional and community levels. Territorial representatives worry that the growth of regional groups will consume resources slated for community development, while regional groups feel that their existence is necessary to best represent the needs of the communities with whom the Territorial government has little contact. In the Baffin region, a

Health Steering Committee was formed comprised of Native and government representatives to help solve this problem (Weller 1990).

Limits to Native community control also arise from a basic disagreement over cultural and minority rights and how far these should extend to groups in society. Divergent positions are held by Natives and government on how much control to confer to Native people. The government maintains that control should be delegated, while First Nations insist that it is inherent.

The main objection to inherent rights for Native people seems to be the view that society should not grant special powers to a segment of the population, especially if that segment is defined on the basis of its membership in a racial or ethnic group. Granting special powers to Native groups conflicts with the dominant ideology of liberal democracy in Canadian society (Weaver 1985). Native self-government in health and the existence of relatively autonomous community-based Native health and social services, then, tests the strength of this ideology, since it implies that power will be distributed unequally from one community to the next (Randle 1986). The main objection to delegated federal control for Native communities over health care is that the federal government will have too much control over community decision-making. This threatens to perpetuate a demoralizing colonial relationship and perhaps the dominance of biomedical services in Native communities.

A case for Native community control and medical pluralism already has been made. Greater control for Native people over their health care is needed for the sake of Native health, Native self-determination and the development of health care options in our society. Until 'special' rights for Natives are entrenched legally, the most compelling argument for treating Native communities differently from non-Native communities may be the urgent need to do whatever is necessary to address the health crises they are facing.

Funding

Federal funding of Native health services is an ongoing issue of concern and dissatisfaction for Native communities. The range of opinion within this issue extends from support for unlimited and unconditional federal funding to Native communities, to support for no federal obligation to fund Native health. Since Native communities currently are economically dependent on the federal government, Native community control will be subject to some federal government conditions; that is, the line of authority from

Chief and Council to the Minister will not disappear completely. (This is despite concerns in some Native communities that the Chief and band council do not represent the traditional structure of authority.)

I argue that the present funding situation represents a point on the continuum which is too close to an assimilationist position; that is, current funding restrictions do not encourage innovative and Native designed health care systems to develop. A balance needs to be reached between this scenario and one in which Native communities have unlimited and unconditional funding from the federal government. It could be argued that, because federal resources are not limitless, neither can rights be limitless. Some Native people might disagree, using the argument that treaty rights to health care entitle them to free and comprehensive health care coverage with no strings attached; and, it is the government's problem if it cannot afford this version of Native health.

However, this position reflects a lack of compromise which will not get Native people very far at the negotiating table. It would be resisted by the government, which would feel that it was writing a blank cheque to Native people without having any control over how the money was spent or over whether or not public health standards were being met.

And, since many Native people are as enamoured with high-tech, professional medicine as are non-Natives, it is likely that they will choose to develop biomedical services alongside preventive programs and traditional healing practices. Simply because of the costs involved, the federal government, with its focus on deficit reduction, would never approve of unlimited expansion of this kind.

The federal government needs to compromise in the area of funding. Though it cannot meet demands for unlimited and unconditional funding for Native health services, it should be possible for MSB to fund alternative transfer projects proposed by Native organizations (Alberta Indian Health Care Commission 1990; Postl and Whitmore 1988; Little Red River Band Tribal Administration 1988) as long as these projects fall within MSB's budgetary limits. In fact, alternative transfer projects which propose a reorientation of health care services, from a primarily curative to a more preventive approach, have the potential to make better use of available health care dollars without compromising health care.

Health Care Orientation

Compromises also need to be reached on a number of levels within the broad issue of health care orientation. For instance, balances need to be struck between the extremes of using only curative or preventive health care services and between employing only professional or lay health personnel; that is, curative, medical services need to be combined with broad-based preventive strategies; and, professionals, paraprofessionals and Native healers need to work in concert. The trend away from a purely medical and curative approach to health care, toward a preventive and broad-based approach, already has begun. However, there is still a great need to channel funding and energies into prevention, as the majority of Native health problems are preventable, and to create links between various community and governmental agencies which have an impact on health.

Currently the services available on many reserves represent a patchwork of programs and not an integrated health care system. Right now, says a Native health administrator, services are fragmented. For example, there may be a prevention program and an aftercare program, but not an intervention program. As one Native informant told me:

> It's always reacting to what's there. What about proacting and planning for the future? It's not there....So when you talk about a community health plan, I hope that they have all these areas covered and that they're planning for the future. Because, if they're not, it's all going to be fragmented services-putting the fire out" (confidential interview).

Filling the gaps in health care coverage, such as between prevention, intervention and aftercare programs, will require that health center staff work in conjunction with community and governmental agencies, such as social services, education and environment, to achieve a well-rounded community-based health care system.

Community-based services occupy the middle ground between an impersonal, homogeneous and state-run system and the "chaos engendered by a completely free market approach to services" (Randle 1986:3). The community-based approach may be defined in the following terms and concepts: autonomous, decentralized, innovative, dynamic, non-bureaucratic, deprofessionalized, holistic, and preventive (ibid). Neufeldt (1989) also defines community-based services as representing a middle-range health care model and uses similar criteria to describe them: they are provided to community residents; they help people to maintain independence and autonomy; they address physical, mental and social well-being; and they are provided by individuals who are part of a health promotion organization. This type of system can best be described as one which is holistic in orientation.

An example of this kind of service is provided by the Battlefords Indian Health Centre in Saskatchewan, which has been offering a combination of preventive and treatment services since 1979 (Health and Welfare Canada 1982). The objective of the centre is to provide total health services to Indian people at the local level. Some of the services offered are Health Education, Public Health, the CHR Program, Dentistry, Nutrition Education, a Hospital Liaison Program, and an Alcohol Program.

An example of a health center which is beginning to employ a holistic approach to health is the health center on the Alexander reserve in Alberta. Health center staff have used the Native symbol of the medicine wheel to draw the connections between health, education, social services and environmental agencies in their community. The health center produces a newsletter, which recently has expanded in scope to address community concerns from alcoholism to the need for youth recreation programs. The newsletter also reports items of general interest to the community, such as birthdays and personal achievements, and informs community members of health center activities, such as upcoming well-baby clinics or immunization days.

Reserve-based health services, clearly, can serve a wide range of functions, and Native people repeatedly have expressed the need for these services. If health services are locally run, people feel a sense of ownership and pride and tend to take a greater interest in health matters. As well, there is a greater chance that health care alternatives will be developed at the local level than in a formal hospital setting. Some nursing stations are being renamed Community Health Centres (Weller 1990) or are being endowed with Indian names, a practice which is symbolic of the increased sense of local control and ownership of community health services. An example of this is the Nisga'a tribe's Wilp Wa uums health center in British Columbia, named after a local plant, which in English means devil's club. In 1980, the National Indian Brotherhood recommended that the establishment of community health centers be given priority (National Indian Brotherhood 1980).

An added benefit of community-based services is their potential to reduce some aspects of federal spending on Native health care. For instance, a large portion of Native health care dollars goes toward medical transportation to the nearest town or city. With health care services close at hand, the need for travel is reduced and costs could be cut substantially. Costs, of course, will depend upon the range and complexity of the services available in communities. For instance, costs would increase if each community offered a full range of high-technology, biomedical services. However, a modest array of curative and preventive community-based health services could satisfy most health needs and eliminate unnecessary travel costs. Furthermore, the proximity of community-based services encourages people to seek health care sooner because they feel more comfortable using these services. Health costs could be reduced in this way by allowing the earlier detection of health problems.

Another balance to strike, within the broader issue of health care orientation, is between the use of biomedical or indigenous community health workers. The role of the CHR (Community Health Representative) bridges this gap nicely, as do the roles of Native healer and midwife (Mardiros 1987). CHRs are recognized widely as key players in health transfer and in Native health development. Their position as 'insiders' (Johnson 1984) allows them to act as culture brokers between Native and non-Native health center staff and between health professionals and community members. Their close connection to community members makes them important health educators as well as advocates for community concerns.

Involving community members in health development is a long process and one in which community health care workers "will play a pivotal role" (Lechky 1991:196). In fact, CHRs see themselves as facilitators of an effective, community-based transfer process (Paul et al 1988). C.L. McLean, of the Council for Yukon Indians, comments, "If we were to truly empower the community in the delivery of health care we would see an enhanced role for the indigenous community health worker" (1990:171). McLean proposes reallocating resources and redefining the role of the indigenous paraprofessional, for instance, by expanding the MSB Health Careers Program to include the paraprofessional health worker. In the North, the number of CHRs is being increased in order to assist in health care reorientation (Weller 1990).

The balance between biomedical and indigenous community health workers also would be achieved by providing traditional healers a legitimate role in health care delivery, particularly if they were allowed to operate a parallel system to biomedicine, rather than being integrated into it or completely isolated from it. Their relationship to biomedicine, of course, is up to Native healers themselves to determine; however, the equal availability of Native healers and biomedical practitioners would best expand the range of real health care options for Native people. Native healers and biomedical personnel can operate out of the same health center without compromising the principles of parallelism and pluralism.

In 1987, the National Indian and Inuit Community Health Representatives Organization made a number of recommendations for improving the quality of Native health services.

These recommendations included that First Nations take a holistic approach to health and incorporate traditional medicine, and that First Nations ensure a full range of high quality services accessible by all Native people (National Indian and Inuit Community Health Representatives Organization 1989). These recommendations confirm the importance to Native people of having a range of available health care options, or medical pluralism. This balance will be achieved when one system does not attempt to dominate the other.

Community Involvement

Involving community members in their health care will be a crucial part of achieving the balance between biomedicine and traditional medicine and between externally-controlled and locally-controlled health care systems. The range of opinion within this issue extends from no control for local people to their total control. The degree of community involvement will vary from community to community, depending on a number of factors, including the level of interest in, and awareness of, health issues; the degree of change desired; the level of expertise within the community; and the extent to which Native people are allowed to control their health services. As Zakus and Hastings (1989) observe of public participation in their literature review on the topic: "meaningful public involvement can only develop out of significant community responsibility and control at all stages" (Zakus and Hastings 1989:182). However, significant community responsibility and control can only develop out of meaningful involvement, a paradox they identify. This paradox suggests that a significant degree of control and participation are required simultaneously in order to develop relevant Native health services.

One Health Director in Alberta is finding that programs cannot be initiated by MSB and be expected to succeed without the support of Elders in the community. Workshops, then, have been run by MSB for Elders first in the hopes of receiving their support and permission. In fact, the Alberta Indian Health Care Commission (1989a) proposes that a Council of Elders serve as a consultative body to MSB to ensure prior consultation with Native communities in establishing government programs for Natives. Such a council would provide overall wisdom and expertise to MSB as well as specific advice in the areas of mental health, alcohol and drug abuse and traditional Native healing practices. It also would ensure meaningful involvement for the community.

Community health boards and committees also are an essential feature of any Native-run health care system

(Health and Welfare Canada 1979; Nuttall 1982). Health committees have been found to play an active role in promoting specific projects in their communities (Martin 1982). The first step to community involvement in these committees, however, is a community-wide awareness of health issues. "People have to be informed. They don't know what is happening," says a Native health administrator in Alberta. In one community, the health board does not have enough knowledge about health issues to know the difference between a preventive and a curative approach to health care. When dealing with the medical professionals in their community, the prevailing attitude is that "a doctor is a doctor - here's your shop, do your thing." So, despite the opportunity for local control, it is important to ask whether or not Native people are aware of health issues, or are interested in accepting this responsibility. The Sandy Bay Band, for instance, found that community concern for health issues was difficult to arouse (Garro et al 1986:283).

More than superficial institutional changes, such as those proposed by MSB in its transfer policy, are required to motivate individuals and communities to take greater responsibility for their well-being (O'Neil 1990:159). Rather, motivation stems from an individual's confidence in his or her ability to affect change. This confidence has been eroded among Native people by years of colonialism and paternalistic attitudes towards them.

Paternalistic attitudes are not the only cause for limited interest in local control over health, however. At the band level, health is only one aspect of a whole range of issues which the Chief, Council and Band Administrator have to deal with. Health, in fact, is often not a priority (confidential interview). This situation could change as an awareness of health issues grows.

It is clear that improvements in health care will not be made without the full participation and meaningful involvement of the community. The key lesson learned through the Northwest Territories health transfer process, in fact, was the importance of maintaining the involvement of aboriginal organizations in the process. This goal was achieved through assurances of their direct involvement and through a process that was slow and staged. Of particular use was the development of a Health Steering Committee (already mentioned with regard to community control) whose members included representatives from all major organizations involved in the process, Native and government. "This ensured that all native groups felt they had involvement in and, indeed, ownership of the process and the outcome" (Weller 1990:136). I was informed by one health administrator in Alberta that there are a number of organizational bodies which have an interest in health care decision-making in Native communities, including Medical Services Branch, band Chiefs and Councils, Tribal Councils, Treaty Area organizations, the Alberta Indian Health Care Commission and The Assembly of First Nations Health Committee. This makes reaching a consensus on health development matters extremely difficult. Steering Committees could allow for the adequate representation of all organizations; however, the challenge of developing such a body would be in achieving and maintaining the involvement of each group.

Native Traditions

The significance of Native symbols, such as the circle and the medicine wheel, and Native traditions such as elders and extended families, should not be overlooked. They can be powerful mobilizing forces in the process of Native health development. As mentioned, one community is attempting to organize its local programs, and communicate an interagency approach to its members, through the use of the medicine wheel symbol. This is just one example of how Native traditions guide community approaches to health development.

Currently, we are witnessing a pan-Indian revitalization of Native culture. Many Native people are rediscovering their roots and identifying closely with Native traditions. Often this identification is part of the process of recovery from addiction or depression. People are enhancing their self-esteem and strengthening their sense of identity by taking pride in their heritage. Native spiritual leaders who have been engaged quietly for years in their practices are now feeling that it is time to speak up. Principles of Native spirituality or cosmology which are becoming well known are the principles of holism, balance, respect for the individual and respect for nature. It is clear that Native people wish to incorporate these principles into their development programs and into their health care systems to different degrees; and, they should be allowed to do so.

In a holistic approach used by Native healers, physical, mental, social and spiritual needs are all considered, as opposed to the biomedical system which treats each kind of problem separately.

> If you talk to a healer, they'll question you. Say you've got stomach problems. How's everything at home? How's your family? They will talk to you and start looking at areas where that illness may be stemming from, understanding that if a spiritual illness is not taken care of it will manifest itself physically (confidential interview).

The holistic approach is especially relevant for treating what this informant identified as spiritual illness. For instance, he feels that there is a whole nation of Indians suffering spiritual illnesses from the effects of the boarding school experience. "Wherever I go, I hear the issue of boarding school....How can you go beyond that when you start talking about health programs?" In order to achieve a balanced approach to health care development, traditional Native institutions and definitions of illness and disease will have to be taken as seriously as Western medical health care institutions and definitions of disease.

Though the unofficial status of Native medicine has made Native people reluctant to admit to using or practicing it, and has convinced some people that it is inferior to biomedicine, many Native people continue to use or practice Native medicine. Native healing traditions will continue to play an even greater role in Native health care if they are accepted by the general public and biomedical practitioners in Native communities. Since Native people have gained greater control over recruiting health professionals to their communities, many have begun searching for individuals who are sensitive to Native culture and supportive of their healing traditions.

Professional and Outside Support

T.N. Madan, writing on community involvement in health policy in India, suggests that the only viable concept of community involvement in health is an incremental one which includes community cooperation at all stages of planning and development, but at the same time "does not absolve the government of its ultimate responsibility for public health" (Madan 1987:618). This is a delicate balance which requires trust between government and Native groups (Canadian Family Physician 1989). Madan's support for a mid-range approach to community participation in health in developing countries can be imported to the Canadian situation. The federal government has a responsibility for Native health which it must maintain while also supporting Native efforts to be self-governing.

> As in most such situations, it is the middle position which seems to hold the best promise. Community participation is no substitute for governmental action, and ordinary people should not be expected to perform those tasks which require specialized knowledge and even fairly advanced training. But to bring about appreciable improvements in public health, people must not be ignored, not only because they can do certain things as well as anybody else, if not better, but also because their participation in many situations is a pre-requisite for the success of the actions initiated by others (Madan 1987:619).

Marlene Castellano, a social worker with experience in training Native health care workers, says that help from non-Native health professionals will be crucial, especially in education and training fields. A new attitude must accompany this approach, however. Castellano says that non-Native people have to be open to learning the languages and cultures of the people they work with and to implementing culturally sensitive programs in the languages of the people they serve. As well, "they have to have the ultimate aim of letting Native communities determine their own health needs and assume control over programs they decide are needed in their communities" (Lechky 1991:195). The role of health professionals and bureaucrats must change from one of authority figure to partner. This process will be resisted; however, their failure to relinquish their top-down, authoritative approach will only discourage Native participation. A lack of participation, in turn, will hinder Native health development and improvements in Native health.

Support for Native health development also must come from the general public. Education of the 'white' community was mentioned several times by Native informants as a requirement of success. It is considered very important that non-Natives understand the underlying issues of why Native health is poor today, and why Native people receive different health services from non-Natives, so that they will "get off Natives' backs" and "stop putting them down." A greater overall understanding of Native policy, and of Native culture, in Canada would help reduce resistance to the idea that Native people need to develop health care alternatives to biomedicine, and that they need to do so on their own terms.

Conclusion

The process of taking over control of health services requires that Native people address a number of issues simultaneously which relate to health. This is demanding work and will take time and ongoing support from MSB, health professionals and the general public. Certain key factors necessary for self-government in health were identified in the Manitoba proposal rejected by Health and Welfare Canada for financial reasons. These criteria serve as a useful summation of what is needed:

> community involvement and participation at every stage, training and development of individuals to assume health system responsibilities, adequate funding with working capital and an undiluted budget base, wholehearted support and cooperation from all branches of the federal government, linkages of health care with other components of community and people development, less complex and less costly bureaucracies, processes and systems, new relationships between Indian community governments and other governments, and recognition of the wisdom of community elders and traditional health teachings (Postle and Whitmore 1988:348).

For these criteria to be met, cultural and ideological gaps in society will have to be bridged and compromises will have to be reached. Resolution of these issues, however, is made urgent by the health conditions in Native communities, by the growing Native population and by the anger that is being generated among Native people by a questionable government commitment to Native self-government and community development.

CHAPTER 5

CONCLUSION

Native health is poor and cannot simply be measured in terms of narrow interpretations of mortality and morbidity statistics. Poor Native health is a product of marginal Native status in Canadian society. Improvements in health will not be achieved until socioeconomic conditions in Native communities improve and local institutions, including health care, become relevant to people.

Health services will only become relevant to people through the meaningful involvement of Native people in the design and delivery of those services. Unfortunately, local interest in health services is curtailed when only minimal degrees of control are conferred to Native communities by the federal government, such as in the case of MSB's health transfer policy. As well, the ability of Native communities to develop health care alternatives outside the present biomedical system is limited by the restrictions of this policy. In the interests of Native health and self-determination, these alternatives must be allowed to develop.

Poor Native health status, and Native demands for self-government and self-determination in all areas of life, have made the transfer of control over health care services a logical and necessary step. However, communities themselves should ultimately decide what kind of approach they want to take. "There's no clear cut path as to what the people want," says a Native health administrator (confidential interview).

The federal government has a long way to go before it will be able to envision a different kind of health system for Native people and before it realizes the depth of differences between Natives and non-Natives that require alternative approaches to health care from the bureaucratic, professional services which presently predominate. MSB's health transfer process merely transplants the old system to Native communities.

As the transfer experiences of more communities become known, the benefits and pitfalls of the Transfer Policy in facilitating community health and empowerment will become more apparent. Policies, in general, are meant to serve as guiding principles and not documents etched in stone. They should, therefore, be open to revision and altered if they fail to serve their intended purpose. Medical Services Branch needs to be flexible in its applications of this policy and in its negotiations with Native bands. Revisions to the policy and process should stem from Native, and not government, interests.

Health policy alone will not engender Native autonomy and improve Native health; rather, 'healthful' policies, meaningful community participation in their implementation, and substantive financial and professional support for community development efforts will lead to improvements in Native health and autonomy. Broad, intersectoral strategies which recognize the relationships between socioeconomic and environmental stresses such as poor housing, polluted rivers and poor health are also needed.

A great deal of Native health development activity is being accomplished by Native people now (O'Neil 1993). Still, bureaucrats, health professionals, researchers and other specialists need to support Native efforts in developing these services and to do this under the direction of Native communities themselves with the goal of Native self-determination in mind.

BIBLIOGRAPHY

Abele, Frances
1990 The democratic potential in administrative expansion: Assessing the impact of the transfer of governing responsibilities from the federal government to the governments of the Yukon and the Northwest Territories. In *Devolution and Constitutional Development in the Canadian North.* ed. Gurston Dacks, 295-315. Ottawa: Carleton University Press.

Adrian Gibbons and Associates
1992 *Short Term Evaluation of Indian Health Transfer.* Ottawa: National Health and Welfare Canada.

Advisory Commission on Indian and Inuit Health Consultation
1980 *Report of Advisory Commission on Indian and Inuit Health Consultation*. T.R. Berger, Commissioner. Ottawa: Health and Welfare Canada

Alberta Indian Health Care Commission
1986 The Neilsen Report in relation to Indian health care: Comments. Photocopy.

1989a Alberta Council of Elders: Terms of Reference. Photocopy.

1989b Position paper on transfer of health programs. May. Photocopy.

1990 All Chiefs Health Conference - Resolutions. Continental Inn, Edmonton, Alberta, March 20 - 22. Photocopy.

n.d. Statement by the Alberta Indian Health Care Commission on the health services transfer proposal of Medical Services Branch. Photocopy.

Bird, L. and M. Moore
1990 The William Charles Health Centre of Montreal Lake Band: A case study of transfer. In *Circumpolar Health 90. Proceedings of the 8th International Congress on Circumpolar Health, Whitehorse, Yukon, May 20-25, 1990*, ed. Brian Postle, Penny Gilbert, Jean Goodwill, Michael Moffatt, John O'Neil, Peter Sarsfield, and T. Kue Young, 47-49. Winnipeg: University of Manitoba Press.

Boldt, Menno and J. Anthony Long
1985 Tribal traditions and European-Western political ideologies: The dilemma of Canada's Native Indians. In *The Quest For Justice: Aboriginal Peoples and Aboriginal Rights*, ed. Menno Boldt and J. Anthony Long, 333-346. Toronto: University of Toronto Press.

Canadian Family Physician
1989 Native health care in transition. *Canadian Family Physician* 35:1597-1599,1602.

Castellano, Marlene B.
1988 Canadian case study - The role of adult education in promoting community involvement in primary health care. *Saskatchewan Indian Federated College Journal* 4(1):23-55.

Crawford, Robert
1977 You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services* 7(4):663-680.

Culhane Speck, Dara
1989 The Indian health transfer policy: A step in the right direction or revenge of the hidden agenda? *Native Studies Review* 5(1):187-213.

Federation of Saskatchewan Indian Nations
1988 Treaty rights and health and social services. *Saskatchewan Indian Federated College Journal* 4(1): 19-22.

Four Worlds Development Project
1990 Transfer: Parts I, II and III. *The Four Worlds Exchange* 2(1):24-39.

Frideres, J.S.
1988 Racism and health: The case of the Native people. In *Sociology of Health Care in Canada*, ed. Bolaria and Dickenson, 135-147. Toronto: Harcourt Brace Jovanovich Canada Inc.

Garro, L.C., J. Roulette, and R.G. Whitmore
1986 Community control of health care delivery: The Sandy Bay experience. *Canadian Journal of Public Health* 77(4):281-284.

Gibbons, Adrian
1988 Health transfer: A preliminary assessment. *Saskatchewan Indian Federated College Journal* 4(1):71-86.

Gilmore, A.
1979 Indian health care: What the dispute is all about. *Canadian Medical Association Journal* 12(1):87-94.

Government of Canada
1979 Indian health policy. In *Report of Advisory Commission on Indian and Inuit Health Consultation.* T.R. Berger, Commissioner. Appendix 2. Ottawa: Health and Welfare Canada.

Gregory, David, Cynthia Russell, Jeanne Hurd, Joe Tyance, and Jeff Sloan
1992 Canada's Indian health transfer policy: The Gull Bay Band experience. *Human Organization* 51(3):214-222.

Haro, A.S.
1987 The role of participation in health promotion. In *Measurement in Health Promotion and Protection*, ed. T. Abelin, et al, 61-65. Copenhagen: World Health Organization Regional Publications, European Series No. 22.

Health and Welfare Canada
1979 Indian health Discussion Paper. Ottawa: Medical Services Branch. Photocopy.

1982 Total health: Battlefords Indian Health Centre Inc. *Community Health Programs*, August 7.

1986a *Achieving Health for All: A Framework for Health Promotion*. Ottawa: Health and Welfare Canada.

1986b A Discussion Paper on the transfer of Indian health programs for consultation with the Indian people. Ottawa: Medical Services Branch, Health and Welfare Canada. Photocopy.

1987 *Health Status of Canadian Indians and Inuit*. Ottawa: Indian and Northern Health Services, Medical Services Branch, Health and Welfare Canada.

1988a The Health Program Transfer Initiative. Ottawa: Health Services and Promotion Branch, Health and Welfare Canada.

1988b The transfer of health services to Indian control. *Saskatchewan Indian Federated College Journal* 4(1):7.

1989a *Health Program Transfer Handbook*. Revised edition. Ottawa: Medical Services Branch, Program Transfer, Policy and Planning Directorate.

1989b Health transfer information package. Ottawa: Medical Services Branch, Program Transfer, Policy and Planning Directorate.

1989c *Health Transfer Newsletter*. Ottawa: Medical Services Branch. Spring.

1989d *Health Transfer Newsletter*. Ottawa: Medical Services Branch. Fall.

1989e *Knowledge Development for Health Promotion: A Call for Action*. Ottawa: Health Services and Promotion Branch.

1990a *Health Transfer Newsletter*. Spring. Ottawa: Medical Services Branch.

1990b *Health Transfer Newsletter*. Summer. Ottawa: Medical Services Branch.

1990c *Health Transfer Newsletter*. Fall. Ottawa: Medical Services Branch.

1990d *Health Transfer Newsletter*. Special Issue. Ottawa: Medical Services Branch.

1990e Medical Services Branch information package: Non-Insured Health Benefits. Ottawa: Medical Services Branch.

Hill, Carole E.
1986 Introduction. In *Current Health Policy Issues and Alternatives. An Applied Social Science Perspective,* ed. Carole E. Hill, 1-5. Southern Anthropological Society Proceedings No. 19. Athens, Georgia: University of Georgia Press.

Hodes, H. and R. Musto
1990 Community participation in Indian health services. In *Multiculturalism and Health Care: Realities and Needs,* ed. R. Masi, 183-184. Downsview, Ontario: Canadian Council on Multicultural Health.

Indian Association of Alberta
1979 Indian health care: A Treaty right. Photocopy.

Indian Chiefs of Alberta
1970 *Citizens Plus*. A Presentation by the Indian Chiefs of Alberta to Right Honorable P.E. Trudeau, Prime Minister of Canada.

Jarvis, George K. and Menno Boldt
1982 Death styles among Canada's Indians. *Social Science and Medicine* 16:1345-1352.

Johnson, Robin
1984 The role of para-professionals in Native health care delivery. In *Report 1984*, 38-43. Seventh Annual Conference of the Association of Canadian Universities for Northern Studies, Ottawa-Hull, 26-28 April, 1984.

Johnston, Mary
1990 *Mawas Diri*: a tool to stimulate community participation. *Health Policy and Planning* 5(2): 161-166.

Kymlicka, Will
1991 *Liberalism, Community and Culture*. Oxford: Clarendon Press.

Lalonde, M.
1974 *A New Perspective on the Health of Canadians: A Working Document*. Ottawa: Health and Welfare Canada.

Lechky, Olga
1991 Transfer of health care holds much promise, lecturers say. *Canadian Medical Association Journal* 144(2):195-197.

Leslie, Charles
1980 Medical pluralism in world perspective. *Social Science and Medicine* 14B:191-195.

Little Red River Band Tribal Administration
1988 A proposal to increase involvement in health care and related services to Band members of Fox Lake, Garden River, and John D'Or. Submitted to Medical Services Branch, Health and Welfare Canada. Photocopy.

Madan, T.N.
1987 Community involvement in health policy: socio-structural and dynamic aspects of health beliefs. *Social Science and Medicine* 25(6):615-620.

Mahler, H.
1981 The meaning of health for all by the year 2000. *World Health Forum* 2(1):5-22.

Mardiros, M.
1987 PHC: Primary health care and Canada's indigenous people. *Canadian Nurse* 83(8):20-24.

Martin, J.D.
1982 Methods to encourage the participation of Native people of northern Canada in health care delivery. In *Circumpolar Health 81. Proceedings of the 5th International Symposium on Circumpolar Health, Copenhagen, 9-13, August, 1981,* ed. B. Harvald and J.P.H Hansen, 96-100. Copenhagen: Stougaard Jensen.

Masi, Ralph
1988 Multiculturalism, medicine and health, part I: Multicultural health care. *Canadian Family Physician* 34:2173-2177.

Masi, Ralph, ed.
1989 *Multiculturalism and Health Care: Realities and Needs. Proceedings of the Canadian Council on Multicultural Health. First National Conference.* Toronto, Ontario, 30 March-1 April, 1989.

McLean, C. L.
1990 The health status of communities employing para-professional indigenous community health workers as the primary health care provider. In *Circumpolar Health 90. Proceedings of the 8th International Congress on Circumpolar Health. Whitehorse, Yukon, May 20-25, 1990*, ed. Brian Postle, Penny Gilbert, Jean Goodwill, Michael Moffatt, John O'Neil, Peter Sarsfield, and T. Kue Young, 170-172. Winnipeg: University of Manitoba Press.

Medicine, Beatrice
1988 Aboriginal views of health. In *Inner City Health: The Needs of Urban Natives. Proceedings of a Conference held in Edmonton, Canada, 28-29 January, 1988,* 46-50. University of Alberta, Department of Continuing Medical Education.

Minocha, Aneeta A.
1980 Medical pluralism and health services in India. *Social Science and Medicine* 14B:217-223.

Moysa, Marilyn
1991 Women want a say in social services: Female Treaty Indians seek role in talks. *The Edmonton Journal,* 2 June:A6.

Musto, Richard
1990 Indian reserves: Canada's developing nations. *Canadian Family Physician* 36:105-108.

National Indian and Inuit Community Health Representatives Organization (NIICHRO)
1989 NIICHRO's comments of National Health and Welfare's response to the recommendations obtained at the Assembly of First Nations National Indian Health Transfer Conference. Photocopy.

National Indian Brotherhood
1980 Submission on Indian health and the Canadian health care system to the Health Services Review '79 (Medicare) from the National Indian Brotherhood, Ottawa, Ontario, 5 March 1980. In *Selected Readings in Support of Indian and Inuit Health Consultation* (1):10-15. Ottawa: Health and Welfare Canada.

Neufeldt, Alfred H.
1989 Strengthening community health services: Framework, issues and strategies. In *Knowledge Development for Health Promotion: A Call to Action*, 185-192. Health Services and Promotion Branch Working Paper. Ottawa: Health and Welfare Canada.

Nichter, Mark
1984 Project community diagnosis: Participatory research as a first step toward community involvement in primary health care. *Social Science and Medicine* 19(3):237-252.

Nishnawbe-Aski Nation
1990 To sustain a nation: Nishnawbe-Aski Nation report on mental health policy consultation. Nishnawbe-Aski Nation, Ontario. Photocopy.

Nuttall, R.N.
1982 The development of Indian Boards of health in Alberta. *Canadian Journal of Public Health* 73(5):300-303.

Oakley, P.
1989 *Community Involvement in Health Development: An Examination of the Critical Issues*. Geneva: World Health Organization.

O'Neil, John

1986 The politics of health in the Fourth World: A northern Canadian example. *Human Organization* 45:119-128.

1990 The impact of devolution on health services in the Baffin region, N.W.T.: A case study. In *Devolution and Constitutional Development in the Canadian North*. ed. Gurston Dacks, 157-193. Ottawa: Carleton University Press.

1993 Aboriginal health policy for the next century. Discussion Paper for the National Round Table on Health and Social Issues, Royal Commission on Aboriginal Peoples, Vancouver, Canada, March 10-12, 1993.

O'Neill, Michel

1990 Healthy public policy: the WHO perspective. *Health Promotion* 28(3). Ottawa: Health and Welfare Canada.

Paul, E., V. Toulouse and E. Roberts

1988 The role of Canadian Native health workers in achieving self-government. *Arctic Medical Research* 47 (Suppl.1):66-69.

Pfifferling, John Henry

1981 A cultural prescription for medicocentrism. In *The Relevance of Social Science for Medicine*, ed. L. Eisenberg and A. Kleinman, 197-222. Dordrecht, the Netherlands: D. Reidel Publishing Company.

Postl, B.

1986 Native health: A continuing concern. *Canadian Journal of Public Health* 77:253-254.

Postle, B. and Moffatt, M.

1988 The health of Canada's Native people: An Overview. *Canadian Family Physician* 34:2413-2419.

Postle, B.D. and R.G. Whitmore

1988 A plan for the transfer of control of health services to Indian communities in Manitoba. *Arctic Medical Research* 47(Suppl.1):346-349.

Quinney, H.

1989 As presented by Henry Quinney, Chairman: Alberta Indian Health Care Commission, at the Medical Services Branch workshop on community development, December 5, 1989, at Red Deer, Alberta. In Alberta Indian Health Care Commission, December 1979 (Newsletter), pp. 8-10.

Randle, Kathryn
1986 *Improving the Delivery of Community-Based Health and Social Services: Proceedings of the Ottawa Conference. November 24-27, 1985*. Ottawa: Canadian Council on Social Development.

Reed, S.C. and J.E. Watts
1990 Indigenous Control of Health Services. In *Circumpolar Health 90. Proceedings of the 8th International Congress on Circumpolar Health. Whitehorse, Yukon, May 20-25, 1990*, ed. Brian Postle, Penny Gilbert, Jean Goodwill, Michael Moffatt, John O'Neil, Peter Sarsfield, and T. Kue Young, 54-58. Winnipeg: University of Manitoba Press.

Rifkin, Susan B.
1985 *Health Planning and Community Participation: Case Studies in South-East Asia*. London: Croom Helm.

Robinson, Sheila A.
1990 Primary health care experience in the developing world: Lessons for Canada? *Canadian Family Physician* 36:95-100

Scott, Kim
1993 Funding policy for indigenous human services. Discussion Paper for the National Round Table on Health and Social Issues, Royal Commission on Aboriginal Peoples, Vancouver, Canada, March 10-12, 1993.

Scott, R.T. and S. Conn
1987 The failure of scientific medicine: Davis Inlet as an example of sociopolitical morbidity. *Canadian Family Physician* 33:1649-1653.

Sherlock, Karen
1990 Indians demand more say in health care decisions. *Edmonton Journal,* 23 March, A10.

Smith, Greg
1987 Health Transfer Conference, Montreal. November 23-24.

Special Committee on Indian Self-Government
1983 Report of the Special Committee on Indian Self-Government. K. Penner, Chairperson. Ottawa: Speaker of the House of Commons.

Starblanket, Noel

1980 Indian health: The dawn of a new era. Presentation by Noel Starblanket at the opening ceremonies of the Battlefords Indian Health Centre - July 26, 1979. In *Report of Advisory Commission on Indian and Inuit Health Consultation*. T.R. Berger, Commissioner. Appendix 4. Ottawa: Health and Welfare Canada.

Stout, M.D.

1991 The role of participation in First Nations health development: Is transfer an empowering process? *Synergy* 3(3):1-2.

Swampy Cree Tribal Council

1990a Implementing primary health care through community control. Paper presented at the 8th International Congress on Circumpolar Health, 23 May, 1990 at Whitehorse, Yukon.

1990b The Treaty right to comprehensive health care and services. Paper presented at the 8th International Congress on Circumpolar Health, 23 May 1990 at Whitehorse, Yukon.

Task Force on Program Review

1985 *Improved Program Delivery - Indians and Natives: A Study Team Report to the Task Force on Program Review*. Ottawa: Minister of Supply and Services Canada.

Tennant, Paul

1985 Aboriginal rights and the Penner report on Indian self-government. In *The Quest For Justice: Aboriginal Peoples and Aboriginal Rights*, ed. Menno Boldt and J. Anthony Long, 321-332. Toronto: University of Toronto Press.

Tupper, C.E.

1988 The changing role of health program managers during a period of transfer of responsibility for health services to Indian people. *Arctic Medical Research* 47(1):338-340.

Union of Ontario Indians and the Assembly of First Nations

1991 *First Nations Health Transfer Forum, November 28-30 1989*. Convened by the Union of Ontario Indians and the Assembly of First Nations. Nipissing First Nation, North Bay, Ontario: Union of Ontario Indians.

Weaver, Sally M.
1985 Federal difficulties with aboriginal rights demands. In *The Quest for Justice: Aboriginal Peoples and Aboriginal Rights,* ed. M. Boldt and J.A. Long, 139-147. Toronto: University of Toronto Press.

1990 Self government policy for Indians 1980-1990: Political transformation or symbolic gestures. A revised copy of a paper delivered to the 1989 UNESCO Conference on Migration and the Transformation of Cultures in Canada, Calgary, Alberta, 21-22 October, 1989.

Weller, Geoffrey
1981 The delivery of health care services in the Canadian North. *Journal of Canadian Studies* 16(2):69-80.

1990 The devolution of health care to Canada's North. In *Devolution and Constitutional Development in the Canadian North*, ed. Gurston Dacks, 121-155. Ottawa: Carleton University Press.

Welsch, Robert L.
1986 Primary health care and local self determination: Policy implications from rural Papua New Guinea. *Human Organization* 45(2):103-112.

Wheatley, Margaret A.
1990 Developing an integrated traditional/clinical health system in the Yukon. In *Circumpolar Health 90. Proceedings of the 8th Annual International Congress on Circumpolar Health, Whitehorse, Yukon, May 20-25, 1990*, ed. Brian Postle, Penny Gilbert, Jean Goodwill, Michael Moffatt, John O'Neil, Peter Sarsfield, and T. Kue Young, 217-220. Winnipeg: University of Manitoba Press.

World Health Organization
1978 *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978*. Geneva: World Health Organization.

1988 *From Alma-Ata to the Year 2000: Reflections at the Midpoint*. Geneva: World Health Organization.

Young, David E. and Leonard L. Smith
1992 *The Involvement of Canadian Native Communities in Their Health Care Programs: A Review of the Literature Since the 1970's*. Edmonton: Canadian Circumpolar Institute.

Young, T.K.
1983 The Canadian North and the Third World: Is the analogy appropriate? *Canadian Journal of Public Health* 74:239-241.

1984 Indian health services in Canada: A sociohistorical perspective. *Social Science and Medicine*. 18(3):257-264.

Zakus, David L. and John E.F. Hastings
1989 Public involvement in health promotion and disease prevention. In *Knowledge Development for Health Promotion: A Call for Action,* 177-184. Health Services and Promotion Branch Working Paper. Ottawa: Health and Welfare Canada.